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ABSTRACT

This document is comprised of the six 1999 issues of a bimonthly newsletter providing information on young children's health and safety for California's child care professionals. Regular features include a column on infant/toddler concerns, a question-answer column regarding medical and health issues, a nutrition column, and resources for child care providers. Periodically featured is information on behavioral, diversity, and school-age care issues. The feature articles for each issue are as follows: (1) "Celebrating the Beauty and Challenge of Diversity in Child Care" (Jan-Feb); (2) "Health and Safety Notes: Child Abuse" (Mar-Apr); (3) "Ensuring Child's Mental Health Is an Invisible Part of Provider's Job" (May-Jun); (4) "CHP Breaks New Ground: Child Care Lead Poisoning and Anemia Prevention Project" (Jul-Aug); (5) "Celebrate Child Health Month and Help California Children" (Sep-Oct); and (6) "Take Action: Build a Child Care Mental Health Consultant Service in Your Community" (Nov-Dec). (KB)

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Child Care Health Connections, 1999
A Health and Safety Newsletter
for California Child Care Professionals

California Child Care Health Program
Graduate School of Public Health,
San Diego State University

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A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

January-February 1999 Volume 12, No. 1

CCHP expands to include new staff

Thanks to the Department of Education and other grant sources, *Child Care Health Connections* is continuing to broaden its scope and content. These important grant sources will allow us to further support your efforts to provide the best possible child care environment.

In this issue, we introduce a new column addressing infant/toddler concerns and written by Cheryl Oku, a well-known parent educator and popular trainer for the West Ed Infant/Toddler Training Program. Our next issue will introduce Paula Gerstenblatt who joins our new Diversity Research and Training Project as Diversity Specialist. Her articles will cover child health, wellness and self-esteem in diverse populations.

This month we will also add to our team of experts a child behavior specialist who will assist with the many behavior issues you encounter in your child care environment. The specialist will be available on the Healthline and will contribute to the newsletter.

The next time you call the Healthline (800/333-3212), please say hello and introduce yourself to our new staff members, and help us to help you by providing topics you would like to see addressed in future newsletters. ❖

Celebrating the beauty and challenge of diversity in child care

by Rahman Zamani, MPH

America is one of the most diverse societies in the world, and California and New Mexico are the two most racially and ethnically diverse states. By the year 2000 it is predicted that the majority of California's residents will be people of color. The changing population and the increasing proportion of minority children in child care demand greater attention by child care providers to the learning, psychosocial and health and safety needs of ethnic and cultural minorities.

Quality child care can promote trust, autonomy and a true sense of well-being in children. It can lead to positive social, emotional, intellectual and physical development. Exposure to a multicultural and multilingual learning environment can greatly benefit children.

Child care providers play an active role in celebrating this diversity. Recognizing cultural diversity, integrating cultural knowledge in day-to-day programming and acting in a culturally-appropriate manner enables child care providers to meet the needs of a diverse population and maximize the benefits.

Providers are challenged by how to provide quality child care to their increasingly diverse population. They are also challenged by the need to consider the impact of

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Child Care Health Connections
January-February 1999
Volume 12, No. 1

Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $15 per year. Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site!
http://ericps.ed.uiuc.edu/cchp/cchphome.html

Ask the nurse...

by Deborah Thompson, RN, MPH

Q Could you explain to me why some children in my child care center do not need to have a TB skin test?

A In the United States the risk of infection with the bacteria causing tuberculosis (TB) is more common in certain populations than others. Some examples of populations identified as being at higher risk of TB infection are families with a history of TB, HIV-infected persons, correctional institution residents and immigrants from countries with a high occurrence of TB. Because of specific risk factors associated with TB infection, the Centers for Disease Control (CDC) and the American Academy of Pediatrics suggested abandoning universal TB screening of children and emphasizing targeted testing of children in high-risk populations.

Tuberculosis is caused by bacteria, *mycobacterium tuberculosis*, which are transmitted mostly through the air (such as by coughing) to susceptible or at-risk individuals. In 1994, the reported number of confirmed U.S. tuberculosis cases was just over 24,000. Tuberculosis is *not* a genetically related disease.

Children with TB are mainly infected by an adult with active TB, often a person in the home.

In August of 1997, the California Community Care Licensing Division amended the child care center licensing regulations in response to public health findings and reports. The new licensing regulations state:

> *"Any child who attends a child care center is required to have a Mantoux skin test for tuberculosis (TB) **only** if the child's medical assessment indicates that the child has risk factors for TB. All children must be assessed for risk factors for TB as part of the medical examination. However, skin testing is required only if determined to be necessary by a physician based on the child's risk factors for TB."*

The Physicians Report Day Care Center Form, LIC 701 was also revised (9/97), and now has an area for the child's doctor or health care provider to indicate that the child has been screened for risk factors associated with TB. If you have not yet seen this form in use, or would like a copy for a new child entering your program to give to his/her doctor, you can call the Healthline at (800) 333-3212 and we will mail or fax you a copy. Do not use the old form. ❖

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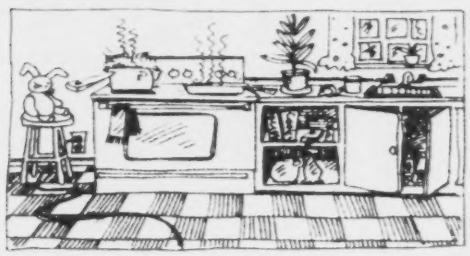
Fire and burn injuries are preventable

by Rahman Zamani, MPH



After motor vehicle accidents and drowning, fire and burns are the third leading cause of unintentional injury deaths among children in California. Although scalds are the most common cause of hospital admission, home fires are the No. 1 cause of deaths among young children.

Risk of fire and burns is related to the age and developmental level of children. Infants may be scalded from drinking liquids or hot tap water; toddlers may spill hot liquids or foods, touch hot surfaces or electrical wiring; preschool and early school-age children may play with matches or lighters. **Children younger than five years of age are especially vulnerable because of their curiosity and ignorance of dangers.**

Young children also have difficulty in leaving burning buildings, even if a smoke detector is sounding. In the majority of home fire-related deaths, children die as a result of smoke inhalation rather than directly from burns. Most deaths from fires occur in the winter months when heating and lighting systems are most utilized.

Most fire and burn injuries are preventable. As a child care provider, you can take steps to reduce the risk of fires and burns in your facility. Include fire and burn prevention in your child care curriculum. Help the children learn about hazards that can cause fire and burns. Teach them that some objects are off-limits for play. Communicate your prevention activities to parents. This can support your efforts and prevent burns and fire at home. Invite a community service representative from the local fire department to your program for a safety workshop.

For more information on preventing fire and burn injuries including handouts, call the toll-free Healthline at (800) 333-3212. For Licensing requirements in California, please refer to Chapter 1, Article 3 (80020) (80023) of general licensing regulations. ❖

Burn and fire prevention tips

- Never leave small children alone.
- Install and regularly check smoke detectors.
- Keep a fire extinguisher on hand, know how to use it and refill it immediately after each use.
- Do not allow children in cooking area without supervision.
- Do not drink or carry anything hot near a child.
- Keep hot foods and drinks away from the edge of tables and counters. Do not leave them on a tablecloth that a child can grab.
- Use the rear burners for cooking. Turn the handles of pots toward the rear or center of stove.
- Test hot food before giving it to a child, including food from a microwave oven.
- Never warm baby bottles in a microwave oven.
- Put barriers around fireplaces, radiators and hot pipes.
- Never use portable, open flame or space heaters.
- Teach children to stay away from hot things and not to play with matches, lighters, chemicals and electric equipment.
- Plan a fire escape route and practice it. Train children how to properly respond to a fire (know the sound of the smoke alarm, two ways out of every room, stop, drop and roll, etc.)
- Use safety devices to cover electrical outlets. Avoid overloading electrical wiring.
- Lower the temperature of your hot water heater to 120° F or lower.
- Store matches, lighters, chemicals and other hazardous items out of reach of children.
- Check for fire and burn dangers, and make the necessary changes.

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To fluoridate or not to fluoridate?

Most of us have fairly strong opinions about how we view health, illness, nutrition, medical care, and public health in general. Our personal beliefs may differ from those of the families we work with. It is not uncommon to disagree with a parent's opinion about immunizations, diet, or use of medications. While it may be easier to write off such beliefs as "wacky" or "weird," most people have definite reasons for their views. You will find it easier to discuss differing viewpoints with parents if you understand what makes an issue controversial, and why people come to the conclusions they do.

Adding fluoride to drinking water has been widespread in this country since the 1950s. Controversy exists over the risks and benefits of the health effects of fluoride. The U.S. Public Health Service, the American Medical Association, the American Dental Association and others believe that fluoridation of public water is a safe, economical and effective way to prevent dental cavities by slowing the breakdown of tooth enamel and speeding up the natural rebuilding. There are also dentists, scientists and nutritionists who are concerned about the health effects of fluoride. Some studies have shown a link between cancer rates and the amount of fluoride in a community's water supply. One side of the controversy says the link is a "causal" one – meaning that fluoride *causes* the cancer. The other side says the link is a "temporal" one – meaning that the two events happen at the *same time*, but one does not cause the other.

Fluorosis is a condition caused by taking in high levels of fluoride over long periods of time. It causes white or brown mottling of the tooth enamel, and pitting in severe cases. The U.S. Public Health Service states that fluorosis is a cosmetic problem but does not cause tooth loss or other dental problems. They also report that increased rates of fluorosis suggest that fluoride exposure is increasing.

What do parents need to consider? Babies who are breastfed by mothers who do not drink tap water or live in areas where the water is not fluoridated may not be getting enough fluoride to develop teeth protected from

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Community Care Licensing update

(Reproduced and abbreviated from the November/December 1998 issue of the Child Care Communique, the newsletter of the San Diego YMCA Childcare Resource Service.)

The Child Care Regulations Reform has been approved by the Office of Administrative Law and became effective Nov. 1, 1998. The Reform was made to comply with the Governor's Executive Order to consolidate regulations, to identify duplicative or obsolete regulations, to clarify terminology and to make the regulations more "user friendly."

After Nov. 1, 1998, the updated edition of the Child Care Center Regulations will be available from the CDSS Warehouse at P.O. Box 980788, West Sacramento, CA 95798-0788. It is also available online at **http://www.dss.cahwnet.gov/getinfo/cacoderegs.html.**

Some of the frequently used Licensing forms such as the Personnel Report (LIC 500), Personnel Record (LIC 501), Personal Rights (LIC 613A), Parent's Rights (LIC 995) and Applicant/Licensee Rights (LIC 9058) are also available online at **http://www.dss.cahwnet.gov/getinfo/pubintro.html**. ❖

Cleaning up: What to use?

by Gail Gonzalez, RN

Well, I have still not received a definitive answer from any source, but I think this proves that the question about the kind of disinfection to use is a legitimate and controversial one. I applaud all the providers who brought it to our attention.

I spoke to many experts, and each of them stressed one point above all others. When there is gross contamination such as blood on a wall, feces on a diapering surface, raw meat juice on a cutting board, or vomit on the carpet, it must be **thoroughly cleaned** before reliable disinfection can take place. But, we are not as clear about *general* disinfection, such as when cleaning tables before eating, diapering surfaces, cribs and mattresses, etc.

We will let you know as reliable information on this issue surfaces. Until then, the dilemma remains. How can we effectively clean and sanitize without using too much of the caregiver's precious time which rightly belongs to the children? ❖

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The key to staying healthy: Is it really our food?

by Vella Black-Roberts, RD, MPH

If you believe the old proverb, "You are what you eat," then you probably also support the belief that food dictates, to a large degree, how healthy you are.

The connection between nutrition and health has been researched and discussed for years. Today it is widely accepted that the more nutritious foods you eat the healthier you will be. This is considered especially true in the case of infants and children. Recent brain research has shown that poor nutritional intake at an early age and on a regular basis can impact the social/emotional behavior and learning ability of young children.

The research findings pose the question: How often and what kinds of foods should children be receiving? Who provides the meals, and are proper temperature and storage guidelines being met?

By definition, nutritious meals in child care must include breakfast, lunch and snacks. This will supply at least two-thirds of the child's daily nutrient needs if children eat on a regular basis. Parents whose children eat meals at the child care site should be sure to request and review the school lunch menu to ensure that meals are meeting the child's nutritional needs. If there are concerns, school officials should be contacted.

Nutritious meals in child care programs are supported by the federally funded Child Care Food Program (CCFP). Many child care programs are part of the CCFP which provides information, technical assistance and trainings to child care providers to assist them in meeting the nutritional needs of young children.

When planning nutritious meals, three main components that make up our food should be considered: protein, carbohydrates and fat. These are our major energy nutrients. Energy is needed to maintain life, to support and promote growth and development, and assist other body processes. Other nutrients such as minerals, vitamins and water support the above nutrients in promoting growth and development.

Comprehending the importance of protein, carbohydrates and fats as energy nutrients should help you further understand the food pyramid featured in our September-October issue. It should also help reinforce the connection between good food choices, well-balanced meals and the importance of certain nutrients in a healthy lifestyle. The final two keys to ensuring nutritional quality are proper food temperature, which varies depending on the food component, and storage.

For more information and ideas on healthy breakfasts, lunches and snacks and how to make this connection call the Healthline Nutrition Link at (800) 333-3212 or your local Child Care Food Program Sponsor. ❖

New health and safety training materials now available

The newly updated (1998) CCHP curricula for training of child care providers, *Prevention of Infectious Disease* and *Prevention of Injuries*, are now available. Topics include Understanding the Spread of Infectious Disease, Preventive Health Practices and Policies, and a wide range of Safety Promotion and Injury Prevention topics for the child care setting.

To order your copy, contact Annette Weatherford at CCHP at (619) 594-3728, by fax at (619) 594-3377, or by e-mail to **weatherf@mail.sdsu.edu**.

Health & safety calendar

January

Family Child Care at Its Best workshops are taking place throughout California. The free workshops are scheduled primarily during evenings and weekends, and participants can earn CEUs from UC Davis. For more information, call Diane Harkins or Kim Bauer at the University Extension at (530) 757-8643.

Relationships in Day Care for Young Children is a course on mental health perspectives sponsored by the San Francisco Psychoanalytic Institute. The course runs from Jan. 20 through May 26. Call (415) 563-5815 for a brochure.

Annual San Diego Conference on Responding to Child Maltreatment will be held Jan. 25-29 in San Diego. Call (619) 495-4940.

February

Annual Local Child Care Community Planning Conference will be held Feb. 16-18 in Sacramento. Call (916) 653-3725 or visit **www.cdpac.ca.gov**.

Infant Development Association Conference will run from Feb. 19-21 in Sacramento. Call (916) 453-8801.

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Behavioral health

Why do children bite?

by Cheryl Oku, Infant Toddler Specialist

Q ***Help! Jana is biting the other children. What can we do?***

A Biting causes more upset feelings than any other behavior in child care programs. We tend to react differently to biting than to other aggressive behaviors because it seems so primitive. Although most infants and toddlers use their mouth to respond to people and explore toys and many 2-year-olds try biting, most do not continue after age 3. Understanding why children bite can help you prevent it and teach young children positive ways to handle their feelings.

Children bite for many different reasons. Careful observation can guide you towards an appropriate and effective solution. *Watch* to see *when* and *where* biting happens, *who* is involved, *what* the child experiences, and *what* happens before and after. *Ask* why the child is biting and whether there is a pattern. Then *adapt* your environment, the program schedule or your guidance methods to teach gentle and positive ways to handle feelings and needs. For instance, when a child:

- experiments by biting your shoulder, you can immediately say "No" in a firm voice. Provide toys to touch, smell and taste for sensory-motor play and toys which respond to an action. Balls, jack-in-the-boxes, and hammering boards are good for experimenting with cause and effect.
- has teething discomfort, you might provide cold teething toys or chewy foods such as bagels.
- is using muscles in new ways, provide a variety of play materials (hard/soft, rough/smooth) and things to do with them (fill, dump, sort and stack). Plan for plenty of active play indoors and outdoors.
- is becoming independent, give some control in making choices (crackers or pretzels?).
- is frustrated by a lack of words, try to give some words, such as "Jaime wants the ball."

When biting happens:

- Intervene immediately between the children. Stay calm. *NEVER bite back.*
- Talk briefly to the child who bit. Look into the child's eyes with a firm expression and voice. Say, "I do not like it when you bite people," or simply "No biting people." Point out how this behavior affected the other child. "You hurt him and he's crying."
- Help the child who was bitten. Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack to help prevent swelling. If possible, encourage the child who bit to help or give comfort.
- Notify the parents and recommend that they see a physician if there are any signs of infection (redness or swelling) or if the skin is broken.
- Involve the parents. Let them know what happened, but do not name or label the children. Ask the parents for help in planning how to deter and handle future biting. There is no need to identify the biter to parents, as it can cause problems between families.

For more information about biting or a copy of the "Biting" Health & Safety Note, please call the Healthline at (800) 333-3212. ❖

California Map to Inclusive Child Care Project is near implementation

by Pamm Shaw, MS, Disability Specialist

California is one of 10 states participating in the *Map to Inclusive Child Care Project*, funded through the Federal Child Care Bureau to the University of Connecticut. The California Child Care Health Program in collaboration with and support from the California Department of Education, Child Development Division, provides staff to the project. The project is committed to substantially improve the delivery of quality child care services to children with disabilities and other special needs in inclusive settings. The focus will be on establishing access to support services needed by child care providers so that they have the resources necessary to care for all children.

The goals of the project include:

- Improving the base level of knowledge of all providers through pre- and in-service training,
- Developing the capacity of providers to care for children with special needs by improving training and ongoing supports,
- Maintaining and improving the infrastructure for inclusive child care,
- Removing barriers to inclusive child care,

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Diversity

(continued from page 1)

complex social/environmental problems which may have negative consequences for children with diverse racial/ethnic and social class backgrounds.

Thanks to the Baxter Foundation, the Child Care Health Program (CCHP) has received a grant to start a Diversity Research and Training Project. The project will focus on strengthening the capacity of child care providers to provide quality child care to biracial/multiracial children.

The project will help providers promote health and deliver appropriate care to multiracial and multiethnic children within a culturally diverse framework. A training curriculum will be developed to help providers better understand the relationship between health issues and racial/ethnic background. ✣

Fluoride

(continued from page 4)

cavities. The same applies to infants who are fed formula mixed with bottled water, and older children who don't drink fluoridated water. Dentists or pediatricians may prescribe fluoride supplements for such children. But what if you don't want your child to ingest fluoride because you consider it a health risk? It can be very difficult to avoid. Drinking bottled water without fluoride and not using toothpaste with fluoride will reduce the amount your child gets. Call your public water system and ask about the level of fluoride in your community water supply. Only 16 percent of the population in California is served by a fluoridated water source.

What can child care providers do? Discuss a child's dental health with parents. Help them access affordable dental insurance and dental services (call your health department for resources). Honor parents' requests to not give their child tap water if they provide you with bottled water. Supervise toothbrushing activities in your program so that children do not swallow toothpaste. If parents agree, use toothpaste without fluoride. Have the fluoride level of your water tested if you have your own well. Above all, talk respectfully to parents about their health beliefs and share all information that you have. ✣

Map

(continued from page 6)

- Facilitating access to inclusive child care for families of children with special needs.

A 32- member team with representatives from state agencies, child care provider organizations and programs, families of children with special needs, training and technical assistance groups, and other interested individuals have developed a strategic plan and will implement a statewide initiative. Tool kits with press releases, resources and information will be available in Spring 1999. Look for a MAP presentation near you. ✣

Pamm Shaw can be reached at (510) 839-1243.

You can help prevent chickenpox

Make sure children get a chickenpox shot

According to the U.S. Centers for Disease Control, every week a child dies from chickenpox complications. It does not have to be this way.

Today, ***chickenpox is preventable***. A chickenpox shot is not required for child care entry but, as a child care provider, you can ask parents to make sure each child gets this shot (except children under age 1 and those who have had chickenpox).

The chickenpox shot will protect children from the potential dangers of chickenpox, such as brain damage and pneumonia. It will protect parents from a week off work with a sick child. It will also protect you from a series of absent children in your care. And it will protect all the children you care for from the spread of a dangerous disease.

Product watch

CPSC releases study on phthalates in teethers and other children's products

The U.S. Consumer Product Safety Commission (CPSC) recently completed a study of the chemical diisononyl phthalate (DINP) used to soften some plastic toys and children's products. They found that few if any children are at risk from the chemical because the amount ingested does not reach a harmful level. As a result, the CPSC is not recommending a ban on such products.

However, several areas of uncertainty indicate that more scientific research is needed. In the interim, the CPSC has requested industry to remove phthalates from soft rattles and teethers. About 90 percent of manufacturers have indicated they already have or will do so by early 1999. Meanwhile, major retailers have removed these products from their shelves until reformulated products are available. ✣

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Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Taking Charge – A Disaster Preparedness Guide for Child Care and Development Centers is available for $10.25 from the California Department of Education, Bureau of Publications. Call (800) 995-4099 or visit **http://goldmine.cde.ca.gov/publications/Pub.html.**

The California Department of Education has produced two videos of how young children acquire a first and second language: *Observing Preschoolers: Assessing First and Second Language Development*, and *Talking with Preschoolers: Strategies for Promoting First and Second Language Development*. Each video costs $12 plus shipping and handling. Call (800) 995-4099.

National Association for the Education of Young Children Early Childhood Resources Catalog which includes books, posters, videos and more, is available free by calling (800) 962-6662.

Online Resources

Food Stamp eligibility is available on the Web on the "food stamp" page at **www.frac.org**. Also available on this Web site is a newly revised fact sheet on poverty in the U.S.

America's Children: Key National Indicators of Well-Being is the second annual report representing an overview of the well-being of America's children. A collaborative effort by 18 federal agencies and drawn from the most recent statistics, it reports on the promises and difficulties confronting our nation's youth. Visit **http://nces.ed.gov/childstats**.

The Healthy Families Program is online at **www.healthyfamilies.ca.gov**.

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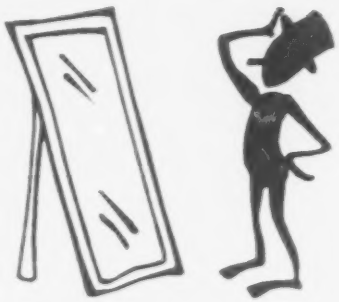
March-April 1999 Volume 12, No. 2

We have a new look!

by Betty Bassoff, DSW



As you can see in this issue, *Child Care Health Connections* has undergone a facelift. In our continuing effort to serve you better and support your goal to provide quality child care, we have added four new pages in a special pullout section and more recurring columns that will address a broad range of child care health topics.

Articles appearing in every issue will address infant/toddler issues, and periodic topics will include behavioral, diversity and school age issues. Our nutrition column will include more recipes to promote and reinforce sound nutritional practices.

The centerfold (pages 5 through 8) has been formatted for duplication and dissemination, and focuses on information you can share with other child care providers and parents. The feature article in each issue and various resources noted in the Resources section on page 12 will be available in Spanish by contacting the Healthline at (800) 333-3212.

We are excited about the diversity and depth of information this new format will provide to child care providers. We hope that it makes your job more satisfying.

If you have any comments or questions, we would like to hear about them. Please call the Healthline at (800) 333-3212 or e-mail Annette Weatherford at weatherf@mail.sdsu.edu. ❖

Immunization update

Mock chickenpox outbreaks

Immunization programs in local health departments are gearing up to hold 'Mock Chickenpox' outbreaks in child care, Head Start and preschool programs.

These events involve children and parents in education on the importance of immunizations, and provide excellent opportunities for radio, TV and newspaper coverage. Those who represent unimmunized children wear red dots on their faces to symbolize a case of chickenpox, while parents and other caregivers learn about the availability of the chickenpox vaccine and the role it plays in protecting children.

If you are interested in participating in such an event, contact your local Immunization Coordinator in your county health department. (Call the Healthline if you need a referral).

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Child Care Health Connections
March-April 1999
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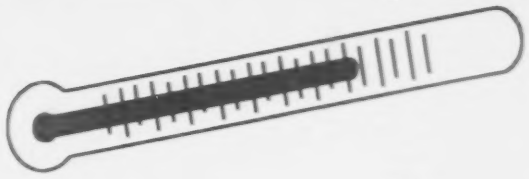
Ask the nurse...



by Deborah Thompson, RN, MPH

Q What should I do when I have concerns about how a parent punishes a toddler in my program?

A Over the last 10 years society has seen a dramatic increase in the number of working mothers, and as a result, more children are cared for outside of their homes. Today it is not uncommon for a child to spend as many waking hours with the child care provider as with his or her family. The unique relationship child care providers have with the child and the family may enable early detection that a family is in trouble or that a child is at risk. A child care provider may be the first to know, or to reasonably suspect, that a child is being abused or in danger of being abused.

Under the California Child Abuse and Neglect Reporting Act (California Penal Code Sections 11164-11174.3) child care providers are required by law to report known or suspected instances of child abuse. As a mandated reporter, you must call your local or county Child Protective Services (CPS) hotline and file a report if you *know*, or if you have a *reasonable suspicion* that:

- a child *is being* abused or neglected, or
- a child *has been* abused or neglected

Early intervention could save a child from harm and keep the family together. As a child care provider, the health and safety of the child should always be your primary concern. Make it part of your job to get to know the parents of the children in your care and work towards building a trusting and sharing relationship with them. Taking the time to talk with parents about normal child development and expectations can often help prevent frustration and anger in the parent.

For example, a 2-year-old tests limits by doing the same thing over and over while also watching for the parent's reaction. A 3-year-old cannot sit still for more than a minute or two, so encourage the parent to plan ahead when doing errands. Then, if an unexpected wait occurs, the parent has toys or activities to keep the child amused and reasonable expectations of the child. Reassure the parent that a child's acting out or unruly behavior is not an indication of failed parenting.

Call the Healthline at (800) 333-3212 to discuss these issues further.

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The infant/toddler world

Responsive caregiving

by Cheryl Oku, Infant Toddler Specialist

Caring for infants and toddlers has its special joys: when a young infant coos and gazes at you with contentment, when a baby eagerly crawls into your lap for a hug, when a toddler solemnly declares "Me do it!" When things are going well, the caregiver and child are engaged in a relationship which has been described as "a dance." They pay full attention to each other, "read" and respond to each other's signals—leading and following in an easy rhythm.

Beyond the pleasure of being a partner in these early relationships, research shows that these experiences directly affect a child's ability to relate to others and to learn, both now and later. A child who receives sensitive, responsive care is generally open, curious, gets involved in play, and recovers well from stress. A child who is stressed by harsh or unpredictable care focuses on having his immediate needs met, rather than on social, emotional, physical and intellectual skills. In addition, repeated stress will cause a child's brain and neurological system to develop in ways which may increase anxiety, hyperactivity, withdrawal or violent tendencies.

So when things don't run smoothly—when the infant just can't be comforted in his usual ways, when the toddler refuses to cooperate or the caregiver loses her patience—the dance is interrupted and the sense of harmony disappears. For instance, "Lakisha just won't stop crying when her mother leaves." "Maria is biting other children practically every day." "Ying has to be held and rocked to sleep." "Ari won't eat his lunch—all he wants is his bottle." How we handle these problems and other daily occurrences can support or interfere with a child's learning and development.

Caregivers are providing sensitive, responsive care when they understand how children develop, adapt to the child's temperament, individual rate of development, biological rhythms and interests, learn and respond to the infant's unique communication style and allow for unhurried time with each child.

The responsive process

Try using this responsive process developed by the Program for Infant/Toddler Caregivers to help solve a problem. Even better, take the time to watch, ask and adapt before problems arise.

WATCH. Begin by just watching and not rushing to do things for the baby. Try to see the world as the child sees it. Watch for both verbal and nonverbal cues. By observing, you will be able to match your response to what the child needs.

ASK. Ask yourself how you can arrange the environment or schedule in ways that will assist the child most. Ask yourself: what message is the child sending? What are the emotional, social, intellectual and physical parts of the message? Be aware of your own feelings which may interfere with hearing or responding to the child's message, including both your current feelings and past experiences.

ADAPT. Engage the child to discover the child's wish. Adapt your actions according to the child's desires. (Acknowledge the child's feelings and wishes, and respond in a way that shows you respect his feelings even though what he wants may not be possible.) Watch how the child responds to your actions. Modify your actions according to the child's response. If the problem is not resolved, begin the process again.

If you take the time to watch when things are going well, you will find it easier to prevent problems or to find solutions which work for each child. In addition to fine-tuning your observational skills and understanding of developmental patterns, you will appreciate each child as a unique individual and develop closer, more rewarding relationships with the children in your care. ❖

California to offer newborn hearing screening program

State Health Director Kim Belshe announced the establishment of California's Newborn Hearing Screening Program, which will begin screening services in July. When fully implemented, the program will provide access to hearing screening services for approximately 70 percent of all newborns in California.

"Approximately 2,000 infants born in California each year will have permanent, significant hearing loss," said Belshe. "Unfortunately, hearing impairment often remains undiagnosed until parents notice that their child is having difficulty learning to speak. Newborn hearing screenings will ensure that infants with hearing loss are identified as soon as possible, so that treatment interventions can begin early enough to assure maximum development of language and communication skills."

The testing of newborns for hearing loss is critical to their development, Belshe said. Through this program, parents of infants will have the opportunity for their newborns to be tested before they are discharged from the hospital so that potential hearing problems can be diagnosed and treated appropriately and effectively. ❖

Look beyond the obvious for poison prevention

When we talk about poison risk, we generally think about children swallowing drain cleaner or bleach, or swallowing a bottle of medication. It is important to realize that there are other sources of childhood and adult poisoning about which we are less aware.

Nicotine patches As more people try to quit smoking and nicotine patches become more common, young infants and toddlers are at an increased risk of poisoning from them. Children can open new packages or find a discarded used patch in the garbage and suck on it. Warn parents and colleagues who are using patches of the risk of poisoning.

Bleach and ammonia Cleaning and disinfecting child care environments are commonly accomplished with products which contain bleach and ammonia; mixing such products can release toxic fumes. Always check cleaning product labels for chlorine and ammonia content. Sometimes we forget or don't realize that a scouring powder or spray cleaner contains one of these ingredients.

Lead Children and adults can suffer severe poisoning from ingesting lead which can be present in a wide variety of products such as: paint that was made before 1978 or dust that contains particles of such paint; certain "home remedies" such as azarcon, greta, pay-loo-ah, some imported pottery, some vinyl miniblinds; water faucets or coolers which have brass fittings; hobby materials for making stained glass, fishing sinkers, or bullets. Make sure that young children have been tested for blood lead levels, your painted surfaces are not peeling, you don't remodel or otherwise disturb lead-based paint without checking with your Lead Poisoning prevention program at the health department, and that you keep toys, floors, and hands free of dirt and dust.

Carbon monoxide Carbon monoxide is a tasteless, colorless, odorless gas which results from incomplete burning of coal or gasoline. When this gas is inhaled it prevents our blood from carrying oxygen to the brain and tissues. People are poisoned from faulty furnaces, car exhaust fumes, burning charcoal inside the house or garage, or space heaters and other appliances that burn gas. You can reduce your risk of carbon monoxide poisoning by installing detectors in your home, having your furnace and other gas appliances inspected annually, and never using charcoal or gas grills inside the house.

Iron pills Children are attracted to brightly colored pills and vitamins that contain iron and may eat them thinking they are candy. Iron pills are frequently prescribed for pregnant women and anemic individuals. Keep all medicines out of reach of children, never call medicine candy, and never give infants or children iron medications without a current prescription from a medical provider.

Insect repellants Not all insect repellants are created equally. Read all labels and follow directions carefully. Do not use products under clothing but only on exposed skin. Don't apply sprays or lotions on cuts, rashes or irritated skin. Never apply such products on an infant or on a child's hands, and wash the product off once indoors. Look for products that naturally repel without insecticides, and always have parents sign a medication form allowing you to apply any repellants or sunscreens in child care. ❖

Help promote recognition of the Week of the Young Child in April

by Sara Evinger

The week of April 18-24 has been set aside to raise awareness about the long-lasting impact that young children's environments and social experiences have on their well-being and ability to learn.

Research shows that children in good quality early education programs have stronger language, pre-math and social skills and better self-perception.

How can centers and family child care associations mark this important week?

- Write your political representatives to advocate for quality care; be specific and share successes;
- Join others to celebrate the Week of the Young Child, Stand for Children, Worthy Wage Day.
- Send a press release to your local media two weeks in advance. Contact NAEYC at (800) 424-2460 or online at http://www.naeyc.org/woycfor more information. ❖

Poisonings are preventable

by Elise Stone, MS, CHES
California Poison Control System

Who gets poisoned?

Most commonly, children under 5 years of age. This year in the United States *two million* children will swallow a poison.

Why children?

Young children are curious. They will eat or drink almost anything —even if it doesn't taste good.

What can be poisonous to your child?

- Medicines (prescription and nonprescription)
- Vitamins
- Iron supplements
- Cleaning, car and gardening products
- Insecticides
- Cosmetics
- Batteries
- Arts and crafts materials
- Plants

When do poisonings happen?

Anytime! Especially near meal times and when the family's normal routine is changed, such as vacations, moving, illness, family stress, entertaining guests

Where do poisonings occur?

Anywhere! Most, however, occur in the kitchen or bathroom, often when a parent is in the room; and in the bedroom where pills may be left on a bedside table.

To receive emergency telephone stickers and a brochure, send a self-addressed stamped envelope to California Poison Control System, UCSF Box 1262, San Francisco, CA 94143-1262 ❖

Poison prevention tips

- Keep all medicines and dangerous products locked up and out of reach when not in use. Instruct visitors or child care providers to do the same.
- Ask for child-resistant containers for all medications. Child-resistant caps are not child proof. The caps only slow them down.
- Never call medicine "candy" in order to get children to take it.
- Avoid taking medicine in front of young children because they learn by imitation.
- If you are called away when using a dangerous product, take it with you.
- Make sure young children and pets are kept safely away from projects such as painting, floor stripping, paint removal, pesticide applications or fertilizer use.
- To prevent lead poisoning keep furniture, walls, window sills and other painted surfaces in good repair. Keep children away from flaking or chipping paint.
- Never transfer dangerous products into food or beverage containers. Each year children are poisoned by drinking poisonous items which were poured into a cup, a glass or a soda can.
- Do not mix chemicals. Read product precautions before use and take warnings seriously. First aid information on labels can be wrong, so if a poisoning occurs, contact the Poison Control Center.
- Identify plants around your home. Get a poisonous plant list from the Poison Control Center. Teach children not to put any part of plants in their mouths.
- Keep Syrup of Ipecac and activated charcoal on hand. Have the poison control number on the telephone; get a sticker from the Poison Control Center.

For poisoning emergencies or information, call (800) 876-4766.

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HEALTH & SAFETY NOTES

California Child Care Health Program

CHILD ABUSE

WHAT A CHILD CARE PROVIDER NEEDS TO KNOW

Child abuse is becoming a serious threat to the health, safety and well-being of children in this country. It is a very sensitive issue that needs to be carefully handled. The National Committee for the Prevention of Child Abuse (NCPCA) defines child abuse as a non-accidental injury or pattern of injuries to a child for which there is no reasonable explanation.

Child abuse consists of different types of harmful acts directed toward children. In physical abuse, children are slapped, hit, shaken, kicked or pushed, or have objects thrown at them causing wounds, broken bones or other injuries. Severe abuse may result in major injury, permanent physical or developmental damage; or even death. Emotional abuse involves humiliation, dishonoring, or other acts carried out over time that terrorize or frighten the child. Sexual abuse consists of a wide range of sexual behavior, including fondling, masturbation and intercourse. Sexual abuse can also involve children in pornography. Neglect, a form of child maltreatment, involves the failure to feed or care for a child's basic needs or to adequately supervise the child.

Child abuse *usually is not* a single act of physical abuse, neglect or molestation, but is typically a repeated pattern of behavior. A child abuser is most often a parent, stepparent, or other caretaker of a child. He or she can be found in all cultural, ethnic, occupational and socio-economic groups.

Reporting suspected child abuse is difficult for providers. As a provider, your job is to protect the child from further potential injury or harm.

You are required by law to report child abuse to your local Child Protective Services agency if you have good reason to suspect that it is occurring.

Remember that you do not have to be sure that abuse or neglect has occurred, but you must have a reasonable suspicion. You are protected as a reporter. If you do not report, you can be in violation of the law. Providers can call their Child Protection Services agency in their county to discuss their concerns, without giving their names. They may also call the Healthline at 1-800-333-3212 to talk about concerns.

GENERAL BEHAVIORS THAT SUGGEST ABUSE OR NEGLECT

The following are behaviors that could indicate abuse or neglect:

- Mood swings
- Fear of certain people
- Grouchiness or irritability
- Is "too good," does not test boundaries
- Uses manipulative behavior to get attention
- Low self-esteem
- Unexplained developmental delays
- Inability to get along with other children
- Is wary of adult contact, rejects affection
- Has a vacant expression, can not be drawn out
- Seeks constant affection from anyone or is very clingy
- Complains frequently of stomach aches or other pains; vomits

Remember that all children occasionally act in these ways.

California Child Care Health Program • 1212 Broadway, Suite 904 • Oakland, CA 94612-1811
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

(Child Abuse continued)

INDICATORS OF THE THREE TYPES OF CHILD ABUSE		
Neglect	**Physical Abuse**	**Sexual Abuse**
PHYSICAL SIGNS		
The Child: • Is underweight or small for age • Is always hungry • Is not kept clean • Is inappropriately dressed for weather • Has not received needed medical/dental care	The Child: • Has unexplained bruises or welts in unusual places • Has several bruises or welts in different stages of healing, in unusual shapes or clusters • Has unexplained burns • Has unexplained broken bones or dislocations • Has unexplained bites or explanation for injury differs from that of parent or caretaker	The Child: • Has difficulty walking or sitting • Is wearing torn, stained or bloody underwear • Has pain, swelling, or itching of genitals • Has bruises, cuts, or bleeding on genitals or anal area • Feels pain when urinating or defecating • Has a discharge from the vagina or penis, or a sexually-transmitted disease
BEHAVIORAL SIGNS		
The Child: • Begs or steals food • Frequently arrives at child care early and leaves later than expected • Has frequent, unexplained absences • Is overtired or listless	The Child: • Tells you he has been hurt by parents or others • Becomes frightened when other children cry • Says the parents or care takers deserve to be punished • Is afraid of certain people	The Child: • Acts withdrawn, over-involved, in fantasy, or much younger than age • Displays sophisticated or bizarre sexual knowledge or behavior • Exhibits excessive or unusual touching of genitals • Tells you that she has a secret she is not allowed to tell anyone • Tries to hurt him/herself

WHAT A CHILD CARE PROVIDER CAN DO TO PREVENT CHILD ABUSE

Child care settings are the only places where young children are seen on a daily basis over an extended period of time by professionals trained to observe their appearance, behavior, and development. As a child care provider you may be the first person to suspect and report abuse and neglect. You may be the biggest source of support and information available to the parents you serve. You can:

- Give families information on child development and appropriate discipline
- Model good child care practices
- Build a trusting relationship with families and discuss concerns
- Help families establish positive relationships with their children
- Refer families to community resources and support services
- Inform parents that you are required to report suspected child abuse
- Know the signs of parent burnout so you can offer support
- Have a parent-staff workshop with information about the issue
- Educate young children about their right to say no

Remember! Never hit or physically injure a child, physically restrain a child, belittle a child or deprive a child of food, sleep or toileting. And above all, if you suspect abuse, you must report it.

California Child Care Health Program • 1212 Broadway, Suite 904 • Oakland, CA 94612-1811
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

Behavioral health

Sleepwetting is common

by Gabrielle Guedet

Note. The term sleepwetting is used rather than bedwetting to emphasize the fact that the child is wetting during sleep. This gives the parent and the child care provider a different view of the situation.

"He sleeps too soundly." "She's just forgetful." "All he has to do is wake up on time." "We don't let her have liquids after 5 PM, or before naps."

As a parent and a child care provider you feel at your wits' end. Some things work for a little while, some things don't work at all. Your schedule is tight and doesn't allow much room. Sleepwetting incidents put everything behind schedule. Neither you nor the child is off to a happy day, and the stress stays with both of you.

Sleepwetting is a common problem. Unfortunately, it is a problem with stigmas attached to it. First, you need to confront your own feelings regarding this issue. The negativity you feel is normal, and it creates more work for you. There is also a personal concern regarding your own effectiveness as a parent or a caregiver. Both you and the child are sensitive and alert to criticism.

Everyone has an opinion about what you need to do regarding this issue. Criticizing, shaming, comparing, punishing, threatening, name-calling or spanking will only increase the stress between you and the child.

There are some productive things you can do:

- Have the child checked by a doctor.
- Listen to the child's thoughts on sleepwetting.
- Be supportive and positive.
- Encourage, motivate and praise, and
- Develop a plan of action with the child.

Working together is the key. Remember: Stress and pressure will cause you and the child to be more anxious, and anxiety can cause frequent urination. Children grow at their own pace. Some gain bladder control early, and some later. Some children sleep very heavily and are not aware of bodily messages. This has nothing to do with intellectual level, it has to do with physical growth.

Gabrielle Guedet, Ph.D., is a clinical psychologist who has worked in the fields of child development, education, play therapy and cross-cultural counseling. She has recently joined our staff as a mental health specialist and can be reached via the Healthline.

Diversity

Working with biracial/bicultural children presents challenges

by Paula Gerstenblatt, MSW

A key ingredient in quality child care is the ability of child care providers to respond sensitively to the cultural needs of children and families. Awareness of cultural diversity has heightened over the past decade, resulting in a vast array of multicultural children's books and curricula. Perhaps most important, it has resulted in a commitment to address racial and cultural issues in recognition of the strong connection between a child's success and his or her racial/cultural self-esteem. As we move forward with our Diversity Training and Research Project, we will try to determine how to meet the unique needs of biracial/bicultural families.

Recently, I spoke with several child care providers about the most pressing issues our project should address. Initiating conversation pertaining to race and culture can be difficult for both child care provider and parents, though typically children speak openly and honestly on this subject. A child's understanding of gender, race and language differences depends on their developmental stage. Questions are inevitable, curiosity is an invaluable trait in young children. Discomfort with discussion about racial and cultural differences is a road block to fostering positive self-esteem for biracial/bicultural children who need to understand their duel identities.

I spoke with a provider who refers to the children of diverse backgrounds in her family child care home as the "United Nations," was caught off guard by the cultural differences that surfaced between herself and an Ethiopian family. Taking a few steps back to consider the different cultural perspectives, she was able to forge a better working relationship with the family.

The sensitivity described above requires that all of us who work with children and families consider ourselves "learners." By listening to children in all their candor, by responding openly to parents, and perhaps most importantly, by willingness to ask questions and seek resources, we will contribute to quality child care environments for all children. ❖

Paula Gerstenblatt is CCHP's Diversity Specialist who has joined our new Diversity Research and Training Project.

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Inclusion insights

Reflecting on inclusion

by Pamm Shaw, MS, Disability Specialist

What does it take to successfully include a child with disabilities or other special needs into your program? Is it education? Training? Support services? A positive attitude? Parent communication and collaboration? Is it the perceived threat of legal action? What makes one person open to new experiences while another is fearful or apprehensive?

While laws and policies exist which can open doors for some people, one cannot legislate attitude change. If a provider does not want to serve a child, s/he will find a way not to, regardless of the legal requirements. And if a provider wants to provide care to a child, she'll learn to use a G-tube, clean a trachea tube, or change diapers on a 10-year-old—regardless of laws and regulations.

Take a few minutes to think about a time in your life when you felt completely accepted. How did you feel at the time? Acceptance means to believe in. Acceptance means love, competence, independence, giving and receiving, being part of a whole.

All of us feel isolated, separate or different at times in our lives. We define ourselves by our experiences, our culture, the environment, our families and our friends. As child care providers, we strive to develop attitudes of acceptance on the part of the children in our care. We teach sharing and caring. We teach taking turns. We teach rules. When we teach, we model, we practice, we grow, we learn.

Think about what it feels like to be accepted. The next time a child with a special need grants you the opportunity to be accepting, or the parent of a child with a disability wants to enroll their child in your care, think about what it takes to accept. ❖

KIDS WHO ARE DIFFERENT

Here's to the kids who are different,
The kids who don't always get As,
The kids who have ears twice the size of their peers,
And noses that go on for days...
Here's to the kids who are different,
The kids they call crazy or dumb,
The kids who don't fit, with the guts and the grit,
Who dance to a different drum...
Here's to the kids who are different,
The kids with the mischievous streak,
For when they have grown, as history's shown,
It's their difference that makes them unique.

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Health and safety calendar

March

National Nutrition Month. This year's theme is "Take a fresh look at nutrition." Call (800) 877-1600, Ext. 5000 and order your supplies today.

10-12: The California Child Development Administrators Association Conference, Oakland, CA. Call Fred Ferrer at (408) 998-1343 or e-mail him at fiferrer @aol.com.

12: California Consortium to Prevent Child Abuse semiannual meeting, Sacramento. Call (916) 498-8481.

21-27: National Poison Prevention Week. See articles on pages 4 and 5 of this issue.

April

Cancer Awareness Month. Call the American Cancer Society at (800) ACS-2345 for information and materials. And don't forget to schedule your annual checkup (and mammogram).

National Child Abuse Prevention Month. See Health and Safety Note on pages 6-7, Ask the Nurse on page 2, and online resources on page 12.

9-10: 17th Annual School-Age Care and Recreation Training Conference. Quantum Leap in Quality School-Age Child Care, Santa Clara. Call (415) 957-9775.

18-24: National Infant Immunization Week and Week of the Young Child. See Immunization Update on page 1 and article on page 4.

19-21: California WIC Annual Conference, Sacramento. Call (916) 448-2280.

22: CAEYC's Annual Legislative Symposium, Sacramento. Call (916) 442-4703.

23: Child Care Professional's Day. See related article on page 11.

California Child Care Healthline:(800) 333-3212

Your link to up-to-date information

The Healthline is available to answer your questions and provide resources to promote the physical and emotional health of children, staff and families in child care settings. Just call!

Nutrition

Nutrition and food allergies

by Vella Black-Roberts, RD, MPH

Food allergies and food intolerances are hard to distinguish. Understanding the difference is important for the child, the family and you, the child care provider. Can you care for children with either of these conditions and provide a safe and healthy environment for them?

A ***food allergy*** is common among infants and young children. It is caused by an abnormal response of the body's immune system to certain foods or food ingredients. Some common food allergies in children are peanuts, other nuts, cow's milk protein, egg whites, citrus fruits, wheat, soy, tomatoes, shellfish and other fish. Providers can recognize symptoms of an allergic reaction. It may include skin reactions such as swelling, hives, rashes; stomach/intestinal reactions such as abdominal pain, nausea, vomiting, diarrhea, gas, and irritability; nose/lung reactions such as breathing problems, nasal congestion and asthma, and even death. These reactions can occur quickly after a food is eaten or over a period of one to two days. The most severe type of reaction is called anaphylaxis, which can occur within moments of eating the offending food, and may impact several parts of the body.

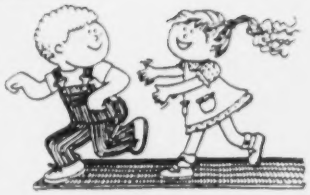
Food intolerance, on the other hand, does not involve the immune system. It is the result of an absence of some chemical or enzyme needed to digest or absorb a particular food. Symptoms a child may experience are abdominal pain, bloating and diarrhea. Many of the symptoms are similar to a food allergy. This is why you are required to have a licensed health care provider diagnose the condition and in writing, tell you the appropriate foods to substitute.

When enrolling a child (and throughout the child's stay in a program), maintaining open communication with the child's family is important. When new foods are added to the child's diet and after you have already spoken with the health care provider, a reaction may occur. It is important to alert families when serving new foods and to allow at least a week before another new food is introduced. Conversely, families should also alert providers to any new foods they may be adding to the child's diet at home.

For more information and local resources on food allergies and intolerances, contact the California Child Care Health Program Healthline at (800) 333-3212 or your local Child Care Food Program Sponsor. ❖

Pooping in his pants

by Gail Gonzalez, RN



Many of you have had to deal with this very issue, so it's not so rare. Caregivers report that they understand accidents during the toilet training process and can understand resistance from a young child, but an older child who starts this behavior confuses them. This is a condition called encopresis.

Definition: Encopresis is defined as voluntary or involuntary passage of stools in inappropriate places by a child over 4 years of age (or equivalent developmental age), who has experienced at least one such event each month for three months.

Encopresis is usually associated with constipation, and 25 percent of affected children also experience bedwetting. The child may try to hide or ignore the problem.

Symptoms: The condition starts by the child withholding bowel movements until a hard mass of stool develops in the bowel (the medical term is 'impaction'). Soiling occurs when a piece of hard stool breaks loose unexpectedly, or soft or watery stool pushes past the impaction. The child cannot control the soiling that occurs from this chain of events.

Cause: The initial cause of stool retention can be dietary, previously painful bowel movements, emotional upset, lifestyle change, disease or medication.

The result of the condition is severe embarrassment, shame and guilt for the child, and frustration for the parent and caregiver. The role of the caregiver in this situation is crucial. You can help the parent understand what is happening and make sure that the family gets advice from their doctor. Once the doctor has prescribed a plan, you can partner with the family in following it.

Solutions: You can help the parent review the child's diet to make sure it is well balanced and includes enough fiber and bulk. The child and parent can be helped by working with a mental health or behavior specialist. You can help the child by understanding that he doesn't want to stink and have everyone know he has pooped in his pants. Allow him to go to the bathroom to clean up and change clothes without any discussion or comment. Above all, do not allow teasing or criticism of the child's behavior.

The expected outcome for encopresis is always good. Call the Healthline if you encounter this problem or have questions for our consulting nurse, nutrition or behavioral specialists. ❖

National Child Care Professional's Day/Provider Appreciation Day

May 7, 1999

A national day of recognition for child care professionals is an opportunity to understand and appreciate the role of child care for working families, highlighting the importance of the parent-provider partnership, and providing opportunities to showcase skilled, nurturing providers and quality child care settings. It is an occasion to energize more capable people to become child care professionals.

Consider these ways to celebrate:

- Bring flowers, or have your child/children make a special card or gift.
- Give your provider a bonus.
- Make lunch for all the children in care that day.
- Offer to help with a field trip.
- Bring dinner for your provider and her/his family.
- Ask your mayor or other local official to issue a proclamation to make the community aware of this special day.
- Some newspapers commit a page at special rates so families can honor their provider with messages of appreciation and photographs. Network with other child care groups and consider planning a community event such as a picnic or theme party.

Contact NACCRRA (National Association for Child Care Resource and Referral Agencies) for more information at (202) 393-5501 or online at http://www.childcarerr.org.

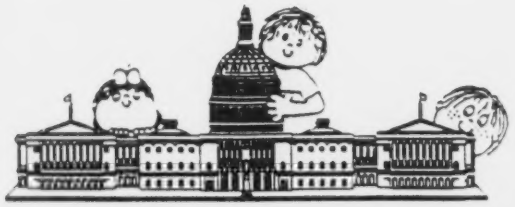
Caring for our children in the 21st century

On Saturday, April 10, 1999, the Health Consultant/ Health Advocate Conference will highlight the Child Care Health Program's successes in Contra Costa County and introduce the new Child Care Health Consultant Project in Alameda County.

The conference will be held from 8 a.m. to 4 p.m. at the John Muir Medical Center at 1601 Ygnacio Valley Road in Walnut Creek. For more information, please contact Dara Nelson at (510) 839-1195.

Legislative update

Marsha Sherman, CCHP Director



On behalf of all child care providers and the families they serve, we urge you to call your legislator and support the passage of **AB212** (Aroner). This bill will establish the **California CARES Program** in five areas of the state, and provide stipends for child care providers when they stay in the child care profession and continue to take classes and workshops. Improved wages and education are the two most important factors in quality child care. This bill is a start to demonstrate that increased compensation will make a difference in the five funded areas, with the hope that within a few years California CARES will be available statewide.

The Child Care Health Program has submitted the **Child Care Health Linkages** legislation again this year. The bill will be sponsored by Assembly Member Gloria Romero of Los Angeles and will be very similar to last year's SB309. The legislation designates six counties where a Child Care Health Consultant will coordinate the establishment of Family Health Coordinators in child care programs. CCHP will work with the target counties and all other interested counties to provide training, technical assistance and resources to promote quality health and safety linkages. For more details, please email Marsha Sherman at cchp *a* mail earthlink.net or call (510) 839-1195.

Another child care health bill to watch is one that will permit child care providers to do some incidental health procedures for the children in their care. We'll have more information on this bill in our next newsletter, or call the Child Care Law Center at (415) 495-5498. ❖

Health and safety training update

A requirement that preventive health practices training must be from an approved organization was signed into law at the end of the 1998 legislative session. It cannot be enforced until regulations are written. Until then, nothing will change regarding where or from whom child care providers take their 15 hours of health and safety training. For more information, call EMSA at (916) 322-4336 or the Child Care Healthline at (800) 333-3212.

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Health Care for All Kids, a brochure with information on health care resources for children in California is available in English and Spanish from the Health Care Services Agency, 1850 Fairway Drive, San Leandro, CA 94577; or call (888) 747-1222 to order a copy.

Online Resources

The Food Allergy Network, a non-profit organization, is offering information on topics such as dealing with specific allergies, product contents, common allergens and more. Visit www.foodallergy. org or call (800) 929-4040.

The National Committee to Prevent Child Abuse web site offers more tips on preventing child abuse. Visit http://www.childabuse.org.

Spanish Health & Safety Notes available from the California Child Care Health Program

1. Precauciones Universales en el Establecimiento de Cuidado Infantil (Universal Precautions in the Child Care Setting)
2. Los Niños Pequeños y los Desastres Naturales (Young Children and Natural Disasters)
3. El Crup en el Establecimiento de Cuidado Infantil (Croup in the Child Care Setting)
4. Cytomegalovirus (CMB) en el Establecimiento de Cuidado Infantil (Cytomegalovirus [CMV] in the Child Care Setting)
5. La Diabetes en el Establecimiento de Cuidado Infantil (Diabetes in the Child Care Setting)
6. La Quinta Enfermedad o "Mejilla Abofeteada" en el Establecimiento de Cuidado Infantil (Fifth Disease or "Slapped Cheek" in the Child Care Setting)

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A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
Graduate School of Public Health, San Diego State University

May-June 1999 Volume 12, No. 3

Ensuring child's mental health is an invisible part of provider's job

by Gabrielle Guedet, PhD

May is National Mental Health Month and this article is dedicated to child care providers who work hard to provide a balanced environment for their young children.

As a child care provider, you are constantly working on the issue of relationships: the relationship of the young child with other children; the relationship of the young child with the staff, the providers and other adults, the relationship of the young child with the environment and your relationship with your staff, colleagues and with families. Your efforts in these areas provide a balanced environment and contribute to a child's mental health.

The term "mental health" does not always mean looking for the problem, sickness or disturbance of the young child. Mental health also means the social and emotional health of the individual. You are an important link in the mental health of the children and their families.

When you observe the different behaviors of the children in your care and you interact with those children by setting limits, by diverting situations, by intervening and preventing "explosions," you provide behavior models that your children may follow. You let them know you care about each one of them. It is such situations that contribute to the mental health of these young children.

When you communicate with the parents of the children, you also provide them with examples of behavior methods and the child's strengths that help to increase the mental health of the families. Because of your primary work with groups of children, you are able to help the families realize when a behavior is "developmentally appropriate" and when a behavior might have other meanings. When you have difficulty communicating with a family or a parent, your struggles

(continued on page 11)

Health and safety tip

Mold and mildew

Two of the most common causes of allergy are mold and mildew, but few of us realize how widespread these organisms are in our own homes.

Though mold may be obvious as black spots in the shower or behind the sink, mold spores are often around when we can't see them. One particular source, common in many child care settings, is the sink, where damp sponges and dishcloths provide the perfect moist environment for mold and mildew. Therefore, be sure to frequently launder dishcloths and replace sponges.

Source: *Allergy and Asthma Network Mother of Asthmatics, August 1998.*

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Child Care Health Connections
May-June 1999
Volume 12, No. 3

Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $15 per year. Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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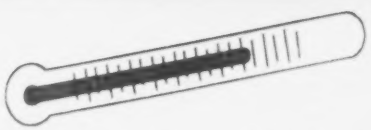
Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site!
http://ericps.ed.uiuc.edu/cchp/cchphome.html

Ask the nurse...

by Deborah Thompson, RN, MPH



QUESTION:

I heard that melanoma is the most deadly form of skin cancer. Is this statement true and what can I do about it for my children and myself?

ANSWER:

Malignant melanoma is a deadly form of skin cancer, but it is also curable if found in its early stages and properly treated. Remember, as with any rapidly growing cancer or disease, preventive care, early detection, and immediate medical attention increase your chances of survival.

The American Academy of Dermatology estimates that 40,000 Americans develop malignant melanoma annually and 6,800 Americans (children *and* adults) die from malignant melanoma skin cancer each year. Melanoma has its beginnings in melanocytes, the skin cells that produce the dark protective pigment called melanin. Melanin is responsible for suntanned skin, acting as partial protection against sun damage. Melanoma cells usually continue to produce melanin and account for the skin cancers appearing in mixed shades of tan, brown and black. Melanoma has a tendency to spread, making it essential to treat early.

A melanoma may suddenly appear without warning, but it may also begin in or near a mole. It is important to know the location and appearance of the moles on our bodies, including birthmarks and blemishes, so any change will be noticeable and detected early. Heredity and atypical moles, which run in families, can help identify persons at higher risk. Excessive exposure to the sun can also be a cause of melanoma.

According to the American Cancer Society, other warning signs of melanomas include:

- Changes in the surface of a mole
- Scaliness or oozing
- Bleeding or the appearance of a bump or nodule
- Spread of pigment from the border into surrounding skin
- Change in sensation, including itchiness, tenderness or pain

Practice good sun-safety habits for yourself and the children in your care when working or playing in the sun. Use a sunblock with a Sun Protection Factor (SPF) of at least 15 and capable of filtering out solar radiation, such as ultraviolet B (UVB) and ultraviolet A (UVA) rays. This helps reduce sunburn and protect against the more common but far less deadly skin cancers, squamous and basal-cell carcinoma. Child care providers need signed permission from the parent or guardian to apply any medications like sunscreen to children in their care.

By educating ourselves and our children with sun-safety habits and periodic examination of our skin for unusual moles or blemishes, we can prevent melanomas. If you would like to discuss a health concern, call the Healthline at (800) 333-3212. ❖

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Infant/Toddler issues

Movin' On: Transitions and continuity of care

by Cheryl Oku, Infant Toddler Specialist

"Jaime is really crawling around and can't stay in here with the babies." "Jesse's talking a lot now. Can she go to the toddler room?" "Isn't it time to move Sung to a preschool? She's really bright and needs to be with the big kids."

At this time of year, we hear a lot about children "moving on." As parents and caregivers we hear those words with mixed feelings. We feel joy because our children are growing and learning new skills. We may also feel dismay when the child moves from a safe, secure setting with a familiar caregiver to a new room or program with new adults.

Experience and research have shown us the importance of having a trusting relationship with a special adult for a child's later social, emotional and intellectual development. We know that young children thrive when they receive warm, responsive care from the same caregiver in a small group over a period of time. These signs of quality care are strengths found in many family child care homes where children may have the same caregiver from infancy through their preschool years.

Larger child care homes and programs with many caregivers must plan carefully to help children form and maintain connections with the adults who care for them. Without this continuity of relationships, we risk that children will not form secure and loving bonds with their caregivers, knowing they will just have to say goodbye in a few months.

What can we do to ease transitions and promote continuity of care?

- ***HELP*** parents understand the importance of ongoing relationships for their child and encourage them to keep a stable child care arrangement with you.
- ***WATCH*** for signs that a child may be outgrowing your program, such as not showing interest in the toys or activities regularly available or exhibiting challenging behavior, such as teasing other children.
- ***ASK*** yourself what new development or skills the child has and what new activities you can provide to continue to challenge the child.
- ***ADAPT*** by making changes in the room, equipment, play materials or activities available (e.g., add props for pretend play, construction or simple art, develop themes to engage the child's interest).

When a move is necessary:

- In larger programs with a range in ages, have a primary caregiver change classrooms with his/her group so children won't have to adjust to both a new room and new caregiver.
- Before moving, be sure the child has a chance to visit the people and place where they will be spending more time. Talk about what they can look forward to ("There is a big sandbox to dig in.")
- Talk about the changes before they happen and how the child might feel. Give children words for their feelings of sadness or missing familiar people and places. ("It's sad to say goodbye to your friends you've known since you were a baby.") Acknowledge your own feelings of loss when you have to say goodbye.
- Help the family make and maintain connections with photos or something special from you (a book or homemade toy), cards or letters. Invite them to visit and stay in touch!

Let's pay attention to the importance of our ongoing relationships with children by how we plan for them and help them as they move on. ❖

Child care for school-age children

School-age child care for ages 5-8 is the same, but different

by Gail D. Gonzalez, RN

The children are older, healthier, ready to begin the stage of "concrete operations" and they have learned to take risks. Your challenge is to stay ahead of them developmentally and recognize the health risks which accompany this stage. Health is a dynamic, ever-changing process. The children need to understand that their health-related decisions will determine where they are on the health continuum.

Personal growth during the elementary years progresses at a more leisurely pace. It claims less energy, so more can be invested in relationships, problem-solving and acquisition of new skills and knowledge. It is a time when certain "delayed start" conditions may become apparent, such as heart disease, diabetes, hearing loss, anemia, bleeding disorders, allergies, postural misalignments, dental problems, vision deficiencies, appendicitis, mental illness and hypertension.

(continued on page 9)

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public Health

We're all in it together. by Lyn Dailey, PHN

When health advice conflicts

Family- and center-based providers often rely on health professionals to help them make decisions about when to exclude children because of illness. Conflicting advice leaves them wondering if anyone really knows what they're talking about.

What is involved in making health and safety recommendations for child care? Health professionals are trained in communicable disease prevention and treatment, some child development, and even community health issues and resources. Rare is the health professional who is also trained as a Child Care Health Consultant. These consultants have a broad understanding of the impact of infectious disease and injury in child care settings. They are well-versed in Community Care Licensing regulations, the Child Care Food Program guidelines, legal issues, and the complicated structure of the child care field. Child Care Health Consultants also have a clearer picture than other health professionals of what happens on a daily basis in child care programs. A good health consultant will not only give you information on the particular disease or condition in question, but will also talk to you about your policies and procedures so that your program will be better equipped to handle future cases.

Where can you turn for help? Child care providers have an amazing array of programs and agencies to turn to for health advice. Your *local health department* has many programs that can provide you with written materials, speakers, statistics and general information on things such as immunizations, lead poisoning, tuberculosis, AIDS, head lice, nutrition and many other topics. *Your own medical practitioner* can often give you guidance on caring for children with health needs. With prior authorization from the parent, a *child's medical practitioner* can give you specific advice on their patient's needs. Your *Food Program* has a lot of nutrition information, and the local *Family Resource Center* can help you find resources for children with special needs. The *Child Care Law Center* and local *licensing office* can help you meet your regulatory guidelines. One of the most comprehensive resources available to you is your *Resource & Referral* agency, and don't forget your *provider association*.

Keep in mind that different agencies will have a different focus or expertise. It is usually beneficial to ask more than one source for information, and ask them to comment on each others' advice. You may find that rather than advice conflicting, it is simply addressing a different aspect or doesn't apply to your situation. This is why it is so important to have a Health Consultant who is familiar with *The National Health & Safety Performance Standards for Out-of-Home Care Programs* by the American Academy of Pediatrics and the American Public Health Association and other such child care-specific documents on health and safety.

While a local Health Consultant will probably know your community best, you can always call the Healthline for consultation and resources. Be specific when you seek advice, and make sure the person you are asking understands that you are a child care provider and not a parent or school. Get a second opinion whenever possible, and rely on your "gut feelings" to guide you. ❖

In Memory of Ruby Brunson
12/20/42 – 3/4/99

The California child care community mourns the passing of Ruby Brunson. Ruby founded and served as Executive Director of the Oakland Licensed Day Care Operators' Association for 21 years. For the past four years she served as Project Director of the Family Child Care Training Collaborative and as President of the California Family Child Care Associations. She was a Wilson appointee to the Child Development Programs Advisory Committee in Sacramento, a devoted advocate for family child care and dedicated to strengthening the role of the family child care provider in delivering quality child care to infants and young children.

To quote CAEYC President Betsy Hiteshew, "Ruby knew the true meaning of the expression *to keep on keepin' on*." She will be sorely missed. ❖

Hepatitis can affect anyone

by Rahman Zamani, MPH

What is hepatitis? Hepatitis is an inflammation of the liver. The liver plays a number of vital roles necessary to keep our body healthy.

What are the causes? There are many causes of hepatitis including exposure to toxins such as alcohol, drugs, chemical poisons, and infections. Liver infections caused by viruses are common and called viral hepatitis. They are named by letters of the alphabet (A, B, C, D, E, G). The most widespread types are A, B and C.

What are the symptoms?

- Children usually don't show any signs or symptoms.
- Adults often suffer from tiredness, loss of appetite, nausea, fever, and jaundice (yellowing of the skin and whites of the eyes) as well as dark brown urine and pale-colored bowel movements (stools).

How is hepatitis spread? The viruses that cause hepatitis A and E are mainly spread through the fecal-oral route (e.g., placing in the mouth of hands and objects such as toys, food and drinks that have been contaminated with the feces or stool of an infected person). Outbreaks of Hepatitis A associated with contaminated food have occurred in the United States. Hepatitis B, C, D and G are spread through blood or other body fluids.

Who is at risk?

Hepatitis A: Anyone can get hepatitis. However, child care programs that care for children in diapers are especially at risk. Others at risk include those having household and sexual contacts with people suffering from hepatitis, and those living in poor hygienic and sanitary conditions.

Hepatitis B and C: These are unusual in the child care setting. Persons in contact with other people's blood (e.g., lab technicians, health care providers or intravenous drug users who may share needles) are at higher risk for hepatitis B. It is also spread by infected mothers to newborn infants through blood exposure at birth. People with open sores, cuts and scrapes can also contract the infection if they come in contact with the blood or body fluid of an infected person.

When should you exclude a person with hepatitis from child care?

Hepatitis A: Exclude the child/adult until one week after the onset of symptoms, or as directed by the health department.

Hepatitis B: The child/adult should stay home until he/she feels well and fever and jaundice are gone.

Chronic hepatitis B: The child or provider who has open sores that cannot be covered should not attend child care until the sores are healed.

Carriers of the hepatitis B and C virus: Exclude these people only if they have uncontrolled biting or oozing skin lesions that cannot be covered.

Whom to notify?

- Notify parents and staff.
- Notify your local health department and request advice. Outbreaks of hepatitis A can be prevented by giving a protective shot of *"immune globulin"* to those exposed.
- Parents and staff must also notify *you* if anyone in their household is diagnosed with hepatitis.

NOTE: *Universal immunization with hepatitis A is currently not recommended. Providers and parents may discuss the issue with their health care providers. Call our Healthline to receive a copy of the Health & Safety Note on Universal Precautions.* ❖

Ways to avoid hepatitis

- Follow the **Universal Precautions** and make sure that **proper hand washing and diaper changing** practices are followed.
- Make sure that all children and staff are up to date on **immunization** for hepatitis B.
- **Clean up blood spills** immediately. Wear gloves when cleaning up blood spills. Wash your hands afterwards.
- **Wear gloves** when changing a diaper soiled with bloody stools. Wash your hands afterwards.
- **Disinfect** diaper-changing areas and surfaces on which blood has been spilled. Use freshly prepared bleach solution.
- If you have open sores, cuts or other abrasions on the hands, wear gloves for changing diapers or cleaning up blood spills.
- **Do not allow sharing of personal items** which may become contaminated with infectious blood or body fluids, such as toothbrushes, food, or any object that may be mouthed.
- Place disposable items contaminated with blood or body fluid in **sealed plastic bags** in covered trash containers. Put other items contaminated with blood or body fluid in sealed plastic bags.
- **Discourage aggressive behavior** such as biting and scratching.

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HEALTH & SAFETY NOTES

California Child Care Health Program

ASTHMA IN CHILD CARE SETTINGS

Asthma is the most common chronic disease among children who use child care. Approximately 10% of all children in the United States have signs and symptoms that suggest asthma, and 80% of these children have symptoms before age five. Therefore, it is highly likely that you will have at least one child with asthma in your program at some time. With appropriate medical, parent and caregiver care, most children with asthma do extremely well in child care settings and can participate in all activities.

Asthma is a condition in which the air passages of the lungs become temporarily narrowed and swollen, causing the child to have difficulty breathing. The symptoms can disappear temporarily with treatment and/or removal from whatever is causing the asthma. The lungs of a person with asthma usually have completely normal function between "attacks."

Normal bronchial tube

Bronchial tube during asthma episode

SIGNS & SYMPTOMS OF ASTHMA:

- Coughing (children often have cough as an early or only symptom of asthma)
- Complaint of tightness in the chest
- Wheezing
- Rapid breathing or difficulty breathing
- Flaring nostrils or mouth open
- Unusual tiredness
- Difficulty playing, eating or talking
- Bluish color to the lips or nails
- Sucking in chest or neck muscles (retractions)
- Decrease in peak flow meter reading

Each child may have different asthma symptoms. The parents and physician should tell you what to watch for.

Asthma is usually started by "triggers," events that begin an asthma attack.

Asthma Triggers

- Allergies to substances such as pollen, mold, animal dander, or dust mites
- Infections, such as colds or viruses
- Irritants, such as cigarette smoke, air pollutants, or other airborne substances
- Cold air or sudden temperature changes
- Exercise or overexertion
- Very strong emotions—laughing, crying, stress can be triggers. (Emotions, to the best of current knowledge, do not "cause" asthma, but can "trigger" an attack.)

Each child will have different triggers. Not every child has triggers that are recognized.

RESPONSIBILITIES OF PROVIDERS

- ☐ **Learn the basics.** Read this health note and a few simple pamphlets about asthma.
- ☐ **Consult with the child's parents, physician and your health consultant.** Learn about the child's symptoms and treatment. It is important to find out the following:
  - How severe is the child's asthma? Has he ever been hospitalized? How many emergency room visits due to asthma? How many attacks this year?
  - How to judge the severity of an attack. Does the child just need to rest? Is treatment needed? Should you call the parent? Do you need to call 9-1-1?
  - What triggers attacks for this child?
  - What medicines does the child routinely take, and which additional medications are to be given when asthma worsens?
  - How to use a nebulizer correctly, especially if the child is using a small machine for inhaled medications.
  - How to use an inhaler and an inhaler with a spacer, if the child is using these.
  - How to use a peak flow meter if the child should be using one.

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(Asthma continued)

- What to do in an emergency (e.g.: administer inhaler or nebulized medications, and call the child's MD or 911).

Collect and record information as required by licensing:

- A new law in California (SB1663, signed into law September 21, 1998) allows licensed child care providers to administer inhaled medication for respiratory problems such as asthma.
- Have form completed by physician or their representative that gives you exact dosing information, including side effects and other possible concerns for each particular child. Renew annually.
- Record medication use and your observations of the child. Share them with the parent/guardian. Call the Healthline (1-800-333-3212) for sample forms.

Provide staff training on asthma, including signs and symptoms of asthma, administration of medications, and the asthma emergency plan.

Modify the environment as needed. Reduce known triggers.

Become familiar with signs and symptoms of worsening asthma. Use the peak flow meter if at all possible, as it detects early worsening of asthma.

Encourage the child to drink lots of fluids daily. This helps prevent "plugged" airways in asthma, especially when an episode occurs.

WHEN AN ASTHMA EPISODE OCCURS

- Remove the child from known triggers, if possible.
- Help the child rest in a sitting position (sitting allows the child to breathe more easily).
- Keep the child relaxed by staying calm yourself and calming other children present.
- Administer medications as directed.
- Have the child blow into the peak flow meter, if possible, to gauge improvement as recommended by the medical provider.
- Call emergency contacts if the child gets worse or does not respond to medication in 15 minutes (parents, physician and emergency response system, if necessary).
- Stay with the child and observe closely until help arrives.
- Document the episode and use of medication.

RESPONSIBILITIES OF THE PHYSICIAN OR OTHER HEALTH CARE PROVIDER

- **Assess the patient's child care setting.** Question parents/guardians about child care staff knowledge and comfort level with asthma control. Ask about level of asthma treatment and monitoring at child care. Ask for an extra set of supplies (peak flow meter, nebulizer, spacer, medications, etc.).
- **Train the parent/guardian and child care provider.** Include observation of the child for asthma, routine medication administration, what to do if asthma worsens, and what to do in an emergency situation. Pay special attention to training parents/caregivers in the use of inhaler (with spacer, if used), nebulizer and peak flow meter if needed. Consider the use of an asthma diary.
- **Review and approve medications.** Update medications and care plan at least annually. Give a signed copy to the child care provider.
- **Act as a resource.** The child care provider, as well as the parent/guardian, may have ongoing questions regarding the child's asthma management.

RESPONSIBILITIES OF THE PARENT/ GUARDIAN AND CHILD

- **Understand the child's asthma management.** Keep a record of the child's asthma in an asthma diary or other format to record daily treatment and changes in response or need for medication.
- **Ensure that your child care provider is thoroughly trained.** This is crucial for appropriate asthma management in child care. Make sure the physician knows the child is in child care and has signed a special care plan for your child. Keep medications and equipment on hand at home, at child care, and on trips away from home.
- **Notify the child care provider of any changes.** Regularly update your schedule and emergency contact phone numbers, and be sure the special care plan is updated as well.
- Help your children describe their symptoms. This helps the child care provider monitor their condition and involves them in the process.

By Lyn Dailey, PHN

(Revised March, 99)

Sources: The American Lung Association, Project Exceptional, PA Chapter of the American Academy of Pediatrics, The Allergy & Asthma Network, Mothers of Asthmatics, and "Asthma Charts & Forms" by Thomas F. Plant and Carla Brennan.

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Behavioral health

Discipline policies and child care

by Gabrielle Guedet, PhD

"Every day that Johnny comes in, he runs to the drama play area and takes the train hat. He won't let any other child wear it. If we try to get him to share, he screams and throws himself on the floor. I wish we could get rid of the train hat."

"Susie doesn't like snack time. She runs and hides and upsets the whole center. We have to disrupt snack time while she is found and brought to the table. Then she knocks over her juice and takes the other children's snacks. It becomes a real nightmare."

Working with groups of children can be both exciting and exacting at the same time. We all find ourselves challenged to meet the child at her/his level and need, but the program, the parents, the children and the staff also have needs. Sometimes these seem to be at cross-purposes.

Developing a disciplinary policy for yourself and your program is a helpful way of solving behavioral problems which arise. Discipline includes consistency, understanding behaviors, flexibility, setting effective and developmentally-appropriate rules and consequences, and encouraging interactions which lead to problem solving.

There are several steps to be taken in the development of disciplinary policy.

1. Assess children's needs, both in your center and at home based on chronological and developmental stages.
2. Review the physical environment of your program for promoting areas for interaction, as well as quiet areas for the children and staff.
3. Ensure that positive expectations (rules), guidance and consequences are presented and understood (by your staff, the child, and the family) for appropriateness to the child's ability to respond.
4. Communicate daily with the families, the staff and the children. A logbook for staff and families to read may prove beneficial. Be specific.
5. Provide specific timetables for actions/consequences to occur, and provide an area for communication, meetings, and discussion among all those involved.
6. Set a written policy which includes each stage of the disciplinary process up to and including possible termination from care in your program. ❖

Diversity

Understanding the ages and stages of racial/ethnic identity development

by Paula Gerstenblatt, MSW

To better understand issues facing bi-racial/bi-ethnic children, familiarity with the ages and stages of identity development is essential. Using a developmental perspective, child care providers can anticipate questions and initiate activities and discussion which will enhance the child's sense of self.

Healthy curiosity does not mean that young children will be able to process the effects of racism. Through age 5, children interpret differences on a literal level and have not yet attached social meaning to racial and ethnic differences. At this stage, children see *hues* of color, not racial categories. For bi-racial/bi-ethnic children, these differences are a natural part of their everyday lives. Children need assurance that differences are positive. In order to project that message authentically, adults must truly believe it.

The following ages and stages of racial/ethnic development were adapted by permission from *I'm Chocolate, You're Vanilla*, by Marguerite A. Wright. Jossey-Bass Publishers, San Francisco, 1998.

I. Racial innocence (ages 0-2). Most children are unable to accurately identify skin color, much less race/ethnicity. They live in a fantasy world where anything is possible, including changes in skin color. They are unaware of why people are one color or the other. Preschoolers tend to see people as individuals rather than members of racial/ethnic groups.

II. Color awareness (ages 3-5). Children can accurately identify their skin color using words like brown, white, tan, and black. Preschoolers can group people accurately by color but not by race or ethnicity. Children who are taught racial bigotry begin to form prejudice towards people with certain skin colors.

III. Awakening to social color (ages 5-7). Children can accurately identify their skin color and begin to make relative color distinctions. Children begin to see skin color as a permanent feature and understand that the effect of sun on their skin is only temporary. Children begin to understand that skin color means something more than color itself. Although they do not fully understand them, children begin to adopt the skin-color prejudices of their friends and family, as well as those presented by the media. ❖

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Inclusion insights

Making inclusion work

by Pamm Shaw, Disabilities Specialist

The inclusion of children with special needs into child care programs presents unique opportunities as well as challenges. The following principles are based upon current research of successful inclusive practices.

The program philosophy promotes acceptance and respect of each child. Children are children first, rather than focusing on their disability or special need. Child-centered models integrate families and specialists as part of the program and team.

There are a variety of funding sources and setting types. There is no one model of inclusive care. Children with disabilities attend child care centers, university lab schools, Head Start, public schools, private programs or family child care.

Inclusion is defined as regular class placement for all children. Recognizing that it takes time, hard work and planning, regardless of the child's type or severity of disability, placement in a typical child care or child development setting is the first choice—with accommodations made and support provided.

Programs have a developmental rather than academic focus. Children are considered active and experiential learners. The natural play setting promotes conceptual rather than rote learning to increase opportunities for children to learn to generalize skills.

Programs have a visionary attitude celebrating the beauty of human diversity. Differences are considered positive and valued. Program staff, environments and activities reflect the community and recognize the impact of the early childhood experience on the lives of families.

Robin Ryan is the parent of 3-year-old Gabe, who has cerebral palsy and is fully included in both a state preschool program in their local school district as well as a child care center. Robin was asked what makes inclusion work for Gabe. She replied:

- Giving him the same opportunities to learn and participate in activities as others in his class.
- Providing him with the necessary support equipment to enable him to sit among his peers at their level.
- Maintaining open and honest communication between program staff and our family.
- Educating myself as a parent on what his rights are as a student.
- Getting creative ideas from program staff.
- Being included in his own neighborhood programs supports the acceptance of his special needs beyond the classroom and into his own community.

The most recent issue of the *Bridges* newsletter, published by the California Head Start State Collaboration Office is dedicated to inclusion and accessing the special services delivery system. You can find this newsletter at their Web site at **www.cde.ca.gov/cyfsbranch/child_development/cddhome.htm.** ✣

School-age children

(continued from page 3)

Healthy children tend to show less emotional upheaval and put more effort into work and hobbies. Children experience a stronger sense of identity and they strive to feel capable and industrious. They care very much about how they compare to others and about whether or not they are inferior to their peers. Helping the child gain competence in personal hygiene, nutrition and lifestyle choices can help a lot.

Children lose some of the spontaneity toward play typical of early childhood and begin to play more traditional games with rules, such as checkers, baseball and soccer. Sports and rigorous physical activity pose the threat of injury and illness to the child. Preventing injuries and being prepared to provide emergency first aid are essential tools for the caregiver of school-age children. Such injuries include sprains, strains, fractures, and trauma to eyes, teeth and abdomen. Children depend on the adults around them to keep them safe. Ensure the use of safety equipment and regularly survey play areas for injury risks and broken equipment.

Clubs are popular because they have rules, but they also may have secrets, intimacy, and offer the child a sense of being special. Children are becoming aware of what it means to belong to a group and what it means to be excluded.

Because children like to form clubs to which they can restrict membership, one unfortunate development may be behavior based on race, gender and economic discrimination. The beginning of the "gang mentality" and the limits to which a person will go in order to belong (i.e. an inclination for violence or using drugs), begin to be tested. This mentality poses a great risk, with unacceptable consequences for the school-age child. Offer the opportunity for clubs, but with a written contract with the children that neither discrimination nor initiations can be included. ✣

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Nutrition

Obesity and hypertension: Is there a life-threatening connection for child care providers?

by Vella Black-Roberts, RD, MPH

Child care providers nurture the children in their care. They are careful to plan well-balanced, nutritious meals, watching the salt, fat, sugar and cholesterol content of the foods they serve. They also plan daily activities for children which involve physical play—indoors or outdoors. But are they as careful and attentive to their own physical, mental health and nutritional needs?

Like most Americans, child care providers are concerned about childhood obesity, and studies show that more than half of the U.S. adult population and nearly one-fifth of America's children and adolescents are overweight. While there aren't any statistics on the percentage of obese child care providers, an informal visual survey of early childhood conferences would suggest that it exceeds 50 percent. Americans spend billions annually on weight loss products and services, and women account for a significant portion of those expenditures. In fact, according to researchers, almost half of all women are trying to lose weight at any given time.

But according to the *Journal of the American Medical Association*, despite the ongoing obsession with weight loss in the U.S., the number of obese Americans continues to increase with no documented increase in cases of high blood pressure (hypertension). This begs the question: Is there a relationship between hypertension and obesity? Physicians and other health care professionals say there is. Hypertension is known as the silent killer. When joined with obesity, the ailment can be life-threatening. Excessive amounts of body fat decrease blood circulation and limit the flow of oxygen throughout the body. This promotes elevation of one's blood pressure and can lead to coronary heart disease, stroke, dyslipidemia (abnormal fat levels in the blood) and diabetes. Health care professionals agree that weight reduction is the first step toward lowering blood pressure, but on the subject of what weight reduction approach is best to achieve that goal, there is no consensus.

Health care professionals do agree that in general, all weight reduction programs should start with a regular exercise component, such as walking. They advise, however, that before starting such a program, individuals should consult their personal health care provider. Make regular visits to your health care provider for a complete checkup including blood pressure screening and lab work (lipid panel, fasting blood sugar, hemoglobin and hematocrit). Smokers should consider enrolling in a smoking cessation program.

To learn more about weight loss, lowering your blood pressure and understanding the connection between the two, contact the Healthline Nutrition Link at (800) 333-3212. Additional resources, exercise and weight promotion tips are available through the American Heart Association and the Child Care Food Program (CCFP). ❖

Health and safety calendar

May

Asthma and Allergy Awareness Month. See Health and Safety Note on pages 6-7.

National Mental Health Month. See lead article on page 1.

National Hepatitis Awareness Month. See "Hepatitis can affect anyone" on page 5.

National Melanoma/Skin Cancer Detection and Prevention Month. See Ask the Nurse on page 2.

High Blood Pressure Month. See Nutrition column on page 10.

Toddler Immunization Month. Are your toddlers' immunizations up to date? Check your records!

13: Child Care Action Forum II, sponsored by the Quality Child Care Initiative. For more information, call (510) 444-7136.

June

2-4: Solutions for Children in Crisis: Imagine a Brighter Future, held in Los Angeles and sponsored by Children's Institute International (CII). For more information, call CII at (310), 274-8787, ext. 116, or visit its Web site at **www.childrensinstitute.org**.

3-4: Voices from the Community: Creating Solutions, the 4th biannual Violence Prevention Conference. Held in Long Beach. For more information, call (213) 240-8279, or fax (213) 250-2594.

21-24: Sharing What Works in Research, Policy and Practice, a national conference on research in child welfare and the Child Welfare League of America (CWLA) Western Region Training Conference. Seattle, WA. Call (202) 942-0289, or visit **www.cwla.org**.

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Mental health

(continued from page 1)

to improve this communication provide those families/parents with behavior methods that can improve their own situations.

To child care providers everywhere: Thank you for being there. Thank you for the work you do. Thank you for providing a balanced and caring environment that allows young children opportunities to explore and learn and understand themselves and their world. ❖

Keeping sand boxes and sand play areas safe is not child's play

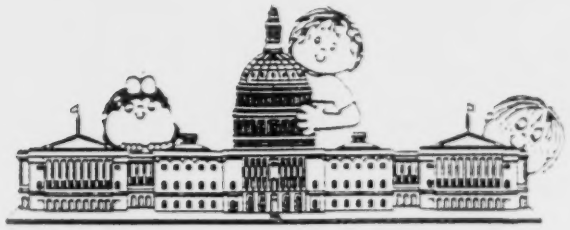
How clean and safe is the sand box/sand play area for the children in your care? Children love the freedom and creativity involved in these activities. Make sure they are safe for them as well by following these guidelines:

- Sand play areas must be distinct from landing areas for any moving equipment such as slides, swings, etc.
- Keep sandboxes covered when not under adult supervision. Fasten the cover to prevent children or animals from getting under it and to prevent contamination by solids or liquids. (Cats need to know it is not a litter box.)
- Equip sandboxes with an effective drainage system that presents no safety hazards.
- Use sterilized sand or smooth-surfaced, fine pea gravel in sand boxes instead of compacting sand.
- Make sure anything used in the sandbox is free of preventable health or safety hazards.
- Remove sand contaminated with urine, feces or other toxic substances with sterilized sand or pea gravel and replace with fresh sand. Treatment of sand with chemicals to attempt to sterilize it within the sandbox is not recommended.
- Sandboxes/sand play areas must be inspected for signs of contamination and safety hazards before each use.
- Sand in sandboxes and play areas must be replaced as needed, and at least every two years.

Source *Caring for Our Children - National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs, 1992.*

Legislative update

by Marsha Sherman, CCHP Director



By the time you read this, **AB 561-Romero**, the Child Care Health Linkages bill, will have been amended to include the following counties: Alameda, San Francisco, Santa Cruz, San Diego, Los Angeles, and Ventura. We are working to establish funding sources for both Health Consultants and Health Coordinators. Check **www.sen.ca.gov** for updates. We need letters of support! Write to your legislators and tell them how this bill would help you, and send copies to Assemblymember Romero. For further information, call Marsha Sherman at (510) 839-1195.

The other legislation we are following is the California Cares Initiative **AB212-Aroner** (Child Care Training and Compensation). The bill proposed this year is very similar to last year's bill. As of this writing, it has not yet been presented to any committees. To keep up to date, please check the Web site referred to above.

Proposition 10 Initiative (California Children and Families First) activities can be confusing and are still unclear in most counties. The Prop 10 statewide committee met for the first time March 25. We encourage people to form collaboratives for funding that meet the basic criteria of the legislation that created Prop 10. An informational meeting of the United Child Care Campaign was held March 29 in Sacramento, where efforts are being made to establish recommended guidelines for funding with the focus on child care issues, including integrated services inclusive of child care. State committee meetings will be held every other Thursday throughout the state, and the child care community is encouraged to attend. For meeting dates and times, address and directions, call Marsha Sherman at (510) 839-1195.

The Child Care Law Center (CCLC) was unable to find a legislator this year to carry the **Incidental Health Care Bill** mentioned in our last newsletter, which would allow providers to perform certain medical procedures. CCLC intends to submit the bill for consideration in the next legislative session. ❖

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Early Warning Signs That Your Child or a Child in Your Care May Need Help is a new brochure developed by The California Department of Education in collaboration with The California Child Care Health Program. A limited number of copies of this publication are available at no cost from CDE Press, Sales Office, California Department of Education, P.O. Box 271, Sacramento, CA 95812-0271, (800) 995-4099.

Child Safety is a 53-minute, closed-captioned, VHS video intended for children, parents and caregivers to help children learn to be safe in today's world. Topics include Staying Home Alone, Riding on Bikes or in Cars, Playing at Home or at School, Computer Internet Safety and Living in Homes with Guns. Available from Janson Video through its Web site at **www.janson.com** under Catalog #20067. ISBN #1-56839-057-2.

Online Resources

Hepatitis Foundation International seeks to increase awareness of the worldwide problem of viral hepatitis and to educate the public and health care providers about its prevention, diagnosis, and treatment. Visit **www.hepfi.org/infomenu.htm**

Spanish Health & Safety Notes available from the California Child Care Health Program

1. La Enfermedad de Mano-Pie-y-Boca en el Establecimiento de Cuidado Infantil (Hand-Foot-and Mouth Disease [Coxsackie A] in the Child Care Setting)
2. ¿Es Seguro Jugar Afuera Durante el Invierno? (Is It Safe to Play Outdoors in the Winter?)
3. El Virus Syncytial del Sistema Respiratorio en el Establecimiento de Cuidado Infantil (Respiratory Syncytial Virus [RSV] in the Child Care Setting)
4. La Nariz Mocosa en el Establecimiento de Cuidado Infantil (Runny Nose in the Child Care Setting. The Snuffly Child or Green Gooky Nose)
5. Tipos de Dietas Vegetarianas (Types of Vegetarian Diets)

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CHP breaks new ground

Child Care Lead Poisoning and Anemia Prevention Project

by Betty Z. Bassoff, DSW

As a result of the opportunity provided by a childhood lead poisoning and anemia prevention grant from the Public Health Trust, the Childcare Health Program (CHP) has succeeded in establishing three new health consultant programs.

Located at Crystal Stairs, Inc. in Los Angeles, Community Connection for Child Care in Kern County, and the Child Care Coordinating Council in Humboldt, each of the new consultant services has chosen a different focus of activities.

Eduardo Gonzales of Crystal Stairs, Inc. is focusing efforts on 100 family child care providers who provide care to children considered to be at high risk for anemia and lead poisoning.

Debra Alberstadt of Kern County focuses on outreach and education to providers using techniques such as lead swabbing of painted surfaces, dishes and mini-blinds, and is collaborating with the Child Care Food Program to perform an initial survey.

April Wallace-McDonald in Humboldt has used the anemia concern as the entry point into her health consultant role. One creative approach she has used to engage providers is sharing recipes high in iron and calcium submitted by child care providers and printed in the agency's newsletter. CHP has been providing technical assistance and support throughout the period of development.

In preparation for the second year, a summit meeting was held during March/April in each county to explore

(continued on page 11)

Have a say in the Prop 10 trust fund

The California Children and Families First Act went into effect Jan. 1, 1999, creating a trust fund from cigarette taxes to benefit early childhood programs. It is critical for child care providers to get involved now, during the development phase. Counties will be crafting their own plans, which need to reflect state guidelines. Since only 20 percent of the funds remain at the state level, it is even more important for you to know what is going on locally. Some things you can do include:

- Get on your local Prop. 10 Commission mailing list (call your county Clerk of the Board of Supervisors).
- Get on your local Child Care Planning Council mailing list.
- Attend meetings or send written information and comments.
- Apply to be on your county's Prop 10 Commission.
- Check out the Foundation Consortium's Web site at **www.wwlc.org** to get current information on Prop 10, policy discussion and resources.

For further information call (310) 888-3523. ❖

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Child Care Health Connections
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Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $20 per year. ***Newsletter articles may be reprinted without permission*** if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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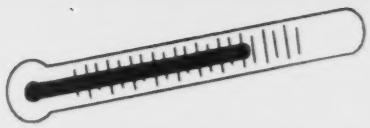
Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our new Web site:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH



QUESTION:

I am a new provider and recently completed my pediatric First Aid and CPR class. Although I learned a lot of good information, I'm not sure that I'll remember everything when a life- threatening situation or condition occurs in my program. Do you have any helpful advice for new providers?

ANSWER:

It may be of some small comfort to know that I have been a licensed RN for twenty years now and still find taking my CPR and First Aid class a challenging experience. As I go through all the new recommendations and sequences, I think about real life situations I have been involved in.

My best advice would be to think more about what it means to be certified in CPR and First Aid and how you can best put this new knowledge and practical experience into the everyday work and home setting. When an accident and/or sudden change in a child's health occurs, try to stay calm and focused on what is really happening. This will help you think clearly and guide you in taking safe and appropriate action.

Remember your ABCs (Airway, Breathing and Circulation) and know how these vital body functions are connected, from a small bruise on the leg to the wheeze of a child with asthma. From time to time, review the textbook provided in the certification class to refresh your memory, remembering to go over the questions that the instructor used when discussing the ABCs.

Airway

Does the child have an open airway? If the child is talking, the airway is still open.

Breathing

Is the child breathing? Conscious children are breathing. However, look for signs of breathing difficulties or unusual breath sounds. Ask someone to explain or go over this again if you are still not sure.

Circulation

Is the child's heart beating? It is beating if the child is conscious. If the child is unconscious, check for the heartbeat by feeling for the pulse. Practice feeling an infant or child's pulse and know what is the normal pulse range for these age groups.

Always know whom to call and contact when an emergency or accident happens. Have emergency telephone numbers for your community and/or county clearly written out, in easy reach of staff and near the telephone. Regularly check parents' and medical providers' telephone numbers for currency and review your written policies and procedures for care of the ill child. If you have further questions or concerns about what to do in an emergency, you can call the Healthline at (800) 333-3212. ❖

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Infant/Toddler issues

Toileting Toddlers

by Cheryl Oku, Infant Toddler Specialist

Summer is a great time for toddlers who are moving from diapers to the toilet. Dressed in lighter layers of clothing, it's easier for a child to notice when he pees or poops in the diaper. When the weather is warm, it is easier to give young children opportunities to try wearing training pants and experience the comfort of clean, dry underwear—or even go without diapers for brief periods. And when you are outside more of the time, it's easier to handle the inevitable accidents.

But first, you need to determine if the child is ready to begin toilet learning.

Watch for the signs

Does the toddler:

- Tell you when s/he has a wet or full diaper and needs a new one?
- Stay dry for two hours and/or wake from naps dry?
- Understand and follow simple directions?
- Pull pants up and down by him or herself?
- Ask to use the potty or toilet or wear underwear?

Ask these questions and address these issues

- *How old is the child?* Between 18 and 24 months, toddlers often show an interest in toileting. But the average age of toilet learning is 30 months.
- *Is the child emotionally ready?* The child needs to be willing and cooperative, not fearful of or fighting the process. If a child protests strongly, it's probably best to wait a while. If you know there are stresses at home, such as a recent move, a new baby or a major family illness, it's also a good idea to wait.
- *Work with the parents* in helping the child learn to use the toilet. Parent-caregiver teamwork will give the child a consistent experience, prevent problems and alleviate anxiety.
- *Discuss with parents the readiness signs and toileting strategies* which have been successful for you. Sometimes a parent is anxious to begin the process, while other times it is the provider. Try to help the child get ready and learn at his own pace. Avoid requiring the child to be trained for the adult's convenience.

Adapt

- *Clothing*: Dress children in pants or shorts with elastic waists or simple dresses. Buttons, zippers, snaps, straps, belts, suspenders, or long or full skirts can interfere with the child's ability to quickly and easily use the toilet. Be sure to have several changes easily available and be matter-of-fact about accidents as part of learning.
- *Routines*: Use normal routines to establish regular potty times, such as upon arrival, after meals and snacks, before and after outdoor play, before and after naps. This helps make toileting a habit.
- *Environment*: You will need only a few basics: a warm, well-lit bathroom, an accessible toilet, handwashing sink and an encouraging adult. A seat adapter or potty-chair will be easier for children. Provide a step stool if you are using an adult-size toilet. To help children who can't immediately potty, set out a basket of children's books or stay with the child.

Remember, toilet learning begins while children are still in diapers:

- You are setting the scene for toileting when you talk to children about how it feels to have a wet or full diaper and how it feels to be clean and dry.
- When you encourage children to dress and undress themselves, learn to wash their hands or clean up, you are helping a child learn skills necessary for toileting.
- When you let children learn through imitation by noticing and watching other children use the toilet, or practicing sitting on the potty with clothes on, you are also encouraging toilet learning.

So, take advantage of these warm summer months and enjoy the process of toilet learning with your toddlers!

We've moved!

The Northern California office of the California Child Care Health Program has moved to:

1322 Webster Street, Suite 402
Oakland, CA 94612-3218

Phone: (510) 839-1195
Fax: (510) 839-0339
E-mail: chp@dnai.com
or Healthline@childcarehealth.org
Web site: www.childcarehealth.org

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It really works!

Imagine a product that prevents colds, diarrhea, food poisoning, hand-foot-and mouth disease, lead poisoning, and a multitude of other diseases both viral and bacterial. Imagine that this product is available for pennies in almost every market you shop in, and most kids love using it. Well, this product already exists and for some reason there are many people out there spending a lot of time, effort and money trying to replace it with less effective and more expensive products.

For years we have known that ***handwashing with plain soap and water*** is the single most effective means of preventing the spread of infectious disease. Yet we also know that many of us do not wash our hands as frequently or as thoroughly as we need to. Why is there such a resistance to simple handwashing and a proliferation of hand sanitizers and antibacterial soaps and lotions?

Yes, I know that child care providers wash their hands more times a day than they care to count, but why reduce a practice that is proven effective in keeping staff, children and environments healthy? The only times I can think of when a provider or child would chose waterless hand sanitizers over soap and water is when there is no water available, and when is that? Almost never, and even then a few wet paper towels or diaper wipes in a plastic bag can do just as well. Think about playing in the park and getting some dog doo-doo on your hands. Which would you prefer to do: a) rub some hand sanitizer on your hands and smear it around, or b) wipe your hands on a damp paper towel that has a little liquid soap on it? The invisible germs that cause colds, flu, and other diseases are invisible but just as real as that dog doo-doo.

A recent study published in *Pediatrics* by researchers in Arkansas showed that *Salmonella* bacteria infections in children were most often traced to the vacuum cleaner and dirt surrounding the front door rather than to contaminated food. Children commonly place dirty hands and objects into their mouths, and handwashing can prevent what we commonly think is "food poisoning." We also know that children who have high levels of lead in their blood can get it from the dirt and dust in their environment that finds its way onto hands and then into mouths.

So how many reasons do we need to return to the basics of thorough handwashing with soap and running water and drying with paper towels? Make the effort to increase proper handwashing in your program by:

- Placing a handwashing poster in the diapering area, the bathroom and the kitchen
- Making soap and paper towels readily available and providing a step stool for children to reach the sink
- *Not* buying antibacterial hand sanitizers and other waterless products for hand "cleansing"
- Monitoring staff and childrens' handwashing techniques and frequency
- Modeling positive health habits for children and parents ❖

What ringworm is—and is not

by Rahman Zamani, MPH

You are well aware that close contact between children in child care settings and schools increases the risk of contagious diseases including ringworm. But is ringworm a "zoonotic" disease—one that can be transmitted between animals and humans? Can children contract ringworm from the sandbox?

Ringworm is a contagious skin disease caused by a group of common fungi (or funguses) called *tinea*. It is *not* a worm. It can affect the scalp, body and nails. Ringworm is spread by direct contact with an infected person or animals such as dogs, cats, rabbits and guinea pigs. It can also be spread indirectly through contact with objects and surfaces which have been contaminated with fungus.

Uncovered sandboxes can be used by cats or other animals as a litter box, and therefore are a potential source for transmission of disease. Harmful insects can also find their way into the sandbox, use it for breeding and cause injuries to children.

As far as ringworm is concerned, the sandbox is *rarely* a source of infection. Although many physicians will say that a child must have gotten it from the sandbox, seldom do fungi from the shed hair and skin of an infected animal stay in the sandbox, especially if the sandbox is dry and exposed to sunlight.

You can prevent the spread of ringworm in your program by taking the following actions:

(continued on page 11)

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Nursemaid's elbow

(It's the toddler's elbow, not the caregiver's)

by Gail D. Gonzalez, RN

Nursemaid's Elbow is technically known as "subluxation of the radial head." Subluxation is a minor dislocation. A dislocation is an injury to a joint causing adjoining bones to no longer touch each other. When a joint is subluxed, the joint surfaces still touch, but not in a normal relation to each other.

This is a very common injury in toddlers and preschool children, and it is rarely seen after the age of 5. Children older than 5 will more likely have a full dislocation from a sports-related injury. If the extremity becomes numb, pale or cold after an injury, call your health care provider. *This is an emergency.* It is more serious and involves more extensive treatment.

How a subluxed elbow occurs

The subluxed elbow occurs from a sudden pull to the straightened arm. It has been known to occur when an adult yanks a child by the arm to make the child behave, hence the name "Nursemaid's Elbow." (It was always the nursemaid who did it!) It can also occur when a child is lifted even playfully by the arms, or when a child holding hands with her parents suddenly lifts her feet to swing and drops all her weight onto her outstretched arms, or when she hangs from the climber in the playground. This hurts and makes it impossible to use the lower arm. The arm will look like it is hanging wrong. Indeed it is. The child will automatically protect it.

Symptoms of a subluxed elbow

What you will notice is the arm held close to the body, slightly bent at the elbow with the palm of the hand facing backward making the thumb be the part nearest the body. There is no swelling, redness or pain at this point. The child refuses to use the hand or arm and complains loudly if you try to move it. When this happens, the child must go to the health care provider, have the arm examined and other injuries ruled out.

Fixing the subluxed elbow

Fixing a subluxed elbow is fairly simple, and physicians usually will teach the parents how to do this because it will probably happen again. Parents might want to show the child care provider as well so that the child doesn't have to wait very long for relief. Fixing this type of injury is called "reduction." The bones need to be realigned and the ligament will move itself to the proper position.

As long as there is no swelling redness, pain or disfigurement of the forearm, perform the following steps to fix the elbow:

1. Support the elbow with one hand, with the other hand, rotate the wrist *slowly* until the child's thumb is facing away from the body.

2. Bend the arm at the elbow and move the palm of the hand toward the shoulder. The hand supporting the elbow will feel a distinct "click," and the child's reaction will be remarkable. The joint will feel as though nothing has happened and the child has full range of motion in the elbow again.

Slings or splints not usually required

After fixing the elbow, there is no need for a sling or splint or any means of immobilization unless reduction has been delayed for more than 12 hours after the injury. In that case, use a sling to immobilize the upper arm while keeping the lower arm horizontal to the floor. If the elbow has three or more episodes of subluxation, encourage the parent to talk to the child's health care provider, because a cast may be necessary for a few weeks.

Subluxation is common in young children and should be avoided. To prevent injuries to elbows, adults must not lift, swing or play with a child by pulling on the arms. Unfortunately, self-inflicted elbow injuries in the play yard are almost impossible to avoid. Children are too young to understand how to avoid the injury. As a general rule, be sure the play yard being used is developmentally appropriate for the child's age and physical abilities.

NOTE: The child's health care provider is the best source of information concerning an individual child.

❖

HEALTH & SAFETY NOTES

California Child Care Health Program

INCLUDING CHILDREN WITH SPECIAL NEEDS

Tips for Child Care Providers

The following suggestions may help include children with disabilities and other special needs in your care. Remember that a child is a child first and each child is different, regardless of whether he has a disability or not. Also, take into account the severity of the disability, the child's age and developmental level when considering adaptations.

Developmental Delays

- Give clear directions, speaking slowly, clearly and using only a few words.
- Move the child physically through the task, so he can *feel* what to do.
- Stand or sit close to the child so you can help when needed.
- Help the child organize his world by providing structure and consistency, e.g. label things with pictures and words.
- Avoid changing activities abruptly. Allow time for adjustment.
- Teach in small steps.

Speech & Language

- Be a good listener.
- Give directions simply and in complete sentences.
- Talk about what you or the child is doing, while you are doing it.
- Have the child talk about what he is doing, asking specific questions.
- Repeat what the child says and add missing words, or ask the child to repeat what you are saying.
- Build on what the child says by adding new information.

Visual Disabilities

- Give specific directions. Avoid the use of words such as this, that, over there.
- Call children by their names. Address them directly, not through someone else.
- Increase or decrease the room light to avoid glaring.
- Use simple, clear, uncluttered pictures that are easy to see.
- Avoid standing with your back toward windows: the glare may make you look like a silhouette.
- Encourage hands-on experiences. Touching, holding and exploring are necessary.
- Ask first if the person needs assistance - don't assume you should help.

Physical/Neurological

- Know the child's strengths and needs, so that independence is realistically encouraged and supported.
- Assist the child with activities he may not be able to do alone, e.g. kicking a ball.
- Be aware of proper positioning techniques.
- Learn how to use and care for any special equipment.
- Don't be afraid to handle the child - she won't break!

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Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

(Including Children with Special Needs-Tips for Child Care Providers continued)

- Help other children understand why "Billy can't walk" and include what Billy can do.
- Try to experience the disability yourself so that you can better understand the child's perspectives.
- Work closely with other agencies and personnel who provide special services (therapists, psychologists, etc.).

Deaf or Hard of Hearing

- Know the degree of hearing loss and what that means for the child.
- Learn how to use and care for the hearing aid or other special equipment.
- Support the child socially.
- Be sure to have the child's attention before giving instructions.
- Speak in full sentences, at normal speed, to the child's face – smile.
- Use visual cues such as pictures or gestures as you talk.
- Encourage the child to let you know when she doesn't understand by using a special signal.
- If the child doesn't understand at first, rephrase your comment rather than repeating it. Learn sign language.
- Provide opportunities for the child to talk.

Social/Emotional/Behavior

- Don't change activities abruptly. Warn the child of any changes in schedule ahead of time.
- Provide routine and structure for the child. Impersonal items such as timers, bells or lights may help.
- Allow the child time to practice new activities away from the group or allow withdrawn children to watch new activities first.
- Seat the child close to you. Give occasional physical and verbal reassurances.
- Let the child bring a familiar object with him when entering new situations or beginning a new activity.
- Help the child make choices by limiting the options.
- Allow the child to have a safe emotional outlet for anger or fear.

Techniques for Managing Behavior

- Respect the child's feelings.
- Manage your own behavior. Model the kind of behavior you want.
- Prevent problems when possible - look at the schedule, structure and physical space.
- Focus on what the child can do and accentuate the positive.
- Follow through with realistic consequences.
- Help children to verbalize, act and understand. Clarify statements and feelings.
- Teach children the "appropriate" behavior.
- Give children reasonable choices.
- Ignore negative behavior if you can.
- Provide developmentally appropriate activities in a safe, nurturing environment.
- Ensure consistency with the family in handling behavior and consequences.
- Have fun. ❖

Pamm Shaw, MS, Disabilities Specialist
(June, 99)

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Behavioral health

Experiences of separation

by Gabrielle Guedet, PhD

As a child care staff member where children spend eight to 10 hours a day, you are dedicated to education and providing quality care for children. However, given the economic status of today's world, many fine teachers in child care are leaving their position to find jobs that will pay a living wage.

What do you do when your/a child's favorite teacher leaves his/her center? How do you respond to your child's sense of loss and anxiety over this separation? What do you do when this situation continues to occur on a regular basis? How does the staff at the center respond to their own sense of loss and to the child's behavioral changes?

Separation is difficult for all of us. However, when separation and loss begin to occur on a frequent basis, there are signs and behaviors we can look for in the young child to help us know that this child is experiencing problems.

Look for changes in the young child's behavior. Increased negativity, misbehavior, increases in temper tantrums, withdrawal, poor sleeping or eating, and being harder to comfort are just some of the differences the child may exhibit. Both staff and parents need to be aware of what is happening with the young child. Seek help or consultation where you feel the need.

> ***There are signs and behaviors we can look for in the young child to help us know a child is experiencing problems.***

As teachers and parents, you can ***be empathetic*** and encourage the young child to discuss his/her feelings. ***Discuss your own feelings***, draw on your own experience of separation and loss. Be open to the range of emotions that may be expressed.

Help ***build a sense of security for the child***, the parents and the staff. Find the consistencies that remain at the center and talk about them. Keep schedules the same as much as is possible. ***Routine is important*** when dealing with anxieties due to separation.

Change happens, and sometimes change happens too often. Be aware of your own experiences, and be open to discussing your concerns with the child, the parents and the staff. By working together, you can all support one another in times of change and transition. ❖

Diversity

Checking the box: Labeling bi-racial/ bi-ethnic children

by Paula Gerstenblatt, MSW

A commonly asked question of biracial/bi-ethnic children is "What are you?" This can be confusing for a young child, particularly if the family has not addressed the issue of racial/ethnic identity. A child's ability to answer the question, "Who am I?" depends on their age and stage of development. When parents and child care providers respond to questions and comments about a child's racial or ethnic identity, this is the most important consideration. The older the child, the greater their ability to respond confidently to such questions with a clear sense of who they are.

Historically, society has imposed racial and ethnic labels on bi-racial/bi-ethnic people. The child's racial and ethnic identity is often assumed to be that of the non-white parent. The notion of pure race or ethnicity is a myth, and fast becoming outdated. Most Americans have a legitimate claim to being bi-racial or bi-ethnic based on historical, voluntary or involuntary mixtures. However, having parents and extended family from different racial/ethnic backgrounds in the present tense creates new and different variables for children to contend with in a society that continues to use racial and ethnic categories as a means of division.

In many instances, bi-racial/bi-ethnic children are physically indistinguishable from the parent of color, or, in the case of a black/white bi-racial child, from children with two black parents. In addition to physical appearance, other factors have great bearing on how bi-racial/bi-ethnic children may identify: relationship to extended family, the racial/ethnic makeup of their community, family philosophy, and the family's income and educational level, to name a few.

Bi-racial/bi-ethnic children may also change how they identify at different stages of their life. This ability to change and adapt should not be viewed as a negative trait, but rather embraced as a logical response to being bi-racial/bi-ethnic. The ability to travel comfortably in more than one world is a tremendous advantage, allowing for a broadened view that includes all possibilities. As a child care provider, recognizing this trait as an asset rather than a liability and supporting the right of each family to make choices—independently of society's expectations and biases—enhances the child's sense of self and provides validation for "who" they are. ❖

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Inclusion insights

Caring for Michael

by Pamm Shaw, Disabilities Specialist

A few months ago I received a phone call through the Healthline. The child care provider was concerned about a 9-month-old Michael, who was not responding to noise or people in a manner that she felt appropriate for his age. She was not sure if he could hear or whether it was an emotional response. He seemed to be otherwise healthy. He had only been in her care about a week, but her experience both as a provider and a parent flashed warning signs. She was apprehensive about approaching the parent, especially since she did not know them very well.

Materials and local referral sources were identified and sent to the provider in duplicate so she could share this information with the parents. The provider spoke with the parent, who also called the Healthline.

Recently, I received a fax from this provider. The child has had tubes put in his ears, is interacting well with the other children and is a completely different child from the one who entered her care a few months ago.

Developing trusting relationships with families takes time and effort. This means that as providers, we take time to nurture and respond to children as individuals, get to know their strengths and needs, develop trust. The same thing needs to happen between providers and families. Parents need to be nurtured and responded to as individuals, acknowledging their strengths and needs, and often they take more time to develop trust than their children.

Research studies show that child care providers and early childhood educators have an 80 to 90 percent accuracy rate referring children for whom they have concerns. Children who are identified and receive early intervention services have much better chances for school success. Take the time to talk to families, share your concerns as well as your joys about working with their children.

If you are unsure, use the Early Warning Signs brochure available in Spanish and English from the California Department of Education Publications by calling (800) 995-4099 or in the *Bridges* newsletter online at **www.cde.ca.gov/cyfsbranch/child_development/cddhome.htm**. You can also obtain a copy from the Healthline at (800) 333-3212.

Thanks to Ena Sifuentes of Gilroy. Michael is doing great! ✣

Product watch

CPSC study finds hazards in child care

A study by the US Consumer Product Safety Commission (CPSC) found that two-thirds of the child care settings studied contained at least one of these hazard areas: soft bedding, inadequate playground surfacing/maintenance, child safety gates, window blind cords, drawstrings in children's clothing, and recalled children's products.

Researchers surveyed 220 licensed child care settings nationally in 1998. Four categories of child care settings were studied: 77 non-profit centers, 68 in-home settings, 52 for-profit centers, and 23 federal General Services Administration-managed child care centers. The complete study from April, 1999. Can be found at **http://www.cpsc.gov/library/ccstudy.html**. Study results include:

- 38 percent of the settings had children wearing **clothing with drawstrings at the neck** (a strangulation hazard)
- 26 percent of the settings had **loops on the window blind cords** (a strangulation hazard)
- 24 percent of the settings did not have safe **playground surfacing** (at least 12 inches of wood chips, mulch, sand or mats on the ground required), and 27 percent of the settings did not keep the playground surfacing well **maintained**.
- 19 percent of the child care settings had cribs containing **soft bedding** (a suffocation and Sudden Infant Death Syndrome [SIDS] hazard).
- 8 percent of the child care settings had cribs that did not meet **current safety standards** (a strangulation and suffocation hazard).
- 5 percent of the settings had **products that had been recalled** by CPSC.

In addition, CPSC's review of state licensing requirements found that many hazards in the study are not addressed in the state requirements.

To address this problem, CPSC created an eight-point checklist for every child care setting. The Child Care Safety Checklist for Parents and Providers is available at **http://www.cpsc.gov/cpscpub/pubs/childcare.html**.

You can also use CPSC's toll-free telephone hotline and Web site to get information about recalled products and what to look for when buying products. Call the hotline at (800) 638-2772 or visit the Web site at **http://www.cpsc.gov**. ✣

Nutrition

Breastfeeding: The benefits are worth it

by Vella Black-Roberts, RD, MPH

Research clearly shows that breast milk is the best form of nourishment for infants. It promotes optimum growth and development and is considered easiest for the baby to digest and absorb. Working mothers typically find breastfeeding manageable, but the process often presents a challenge for child care providers.

The benefits associated with breastfeeding far outweigh the challenges and are worth the effort it may take for the provider to support the parent's decision to continue breastfeeding. Benefits include a reduced risk of Sudden Infant Death Syndrome (SIDS), breast cancer and increased immune function in infants. Breastfeeding also has the potential to reduce health costs by reducing the incidence of osteoporosis and ovarian, cervical and certain childhood cancers, lowering respiratory tract infections, ear infections, Type I insulin-dependent diabetes mellitus, and a host of other illnesses. Benefits can be detected after as little as 12 weeks of breastfeeding.

Providers can help breastfeeding moms

Armed with this information, child care providers can work more closely with families to promote breastfeeding in their child care programs.

- Providers can offer a quiet place for the mother to breastfeed at drop-off, during the day and at pick-up.
- If the parent works close by, they can develop a way to contact the parent to make a quick trip to the program to breastfeed, or try to stick to a feeding schedule with the mother—one that works for all parties.

Reminders

- Always have supplemental feedings available, and be sure to label all bottles with the infant's name and the date pumped, freeze or refrigerate immediately. Monitor dates closely and discard refrigerated milk after 24 hours.
- Defrost breast milk in warm water. *Never* use a microwave, not only will it quickly and unevenly overheat the milk which can burn the baby's mouth, microwaving also destroys important nutrients.
- When feeding, offer only the amount you think the infant will drink because breast milk cannot be refrozen or reused. Only give breast milk to the infant it is intended for; do not share breast milk.

Parents and providers most stay in close communication so that both are informed of any changes in the infants' eating habits and/or feeding problems. Most importantly, if the parent is unable to come to breastfeed on any day, the provider should be advised immediately and an alternative plan established. If the parent is unable to be consistent and there are frequent problems, ultimately the infant's growth and development are affected.

For more information on breastfeeding, contact your Child Care Food Program Sponsor or call the Healthline at (800) 333-3212. ❖

Health and safety calendar

July 7-9: 13th National Roundtable on Child Protective Services Risk Assessment, San Francisco. Discussion and presentation of the latest research, updates from ongoing projects and initiatives under way. Contact Mickey Shumaker at American Humane Association, (303) 925-9416 or (303) 792-9900; fax (303) 792-5333; email mickey@americanhumane.org.

August 6-7: Kaleidoscope '99, 11th annual Northern California Early Childhood Education Conference, Sacramento. Explores human connections, critical thinking skills and transitions. Contact NCECE, (916) 491-6893, ext. 99.

August 18-20: The California Home Education Conference, Sacramento. Focuses on home schooling experiences, challenges and successes. Contact Jay Simpson, (916) 344-6600.

August 18-21: Playground Safety 1999, an international conference, University Park, PA. (800) 778-8632.

September 21-23: 15th Annual California Child Development Conference, Anaheim. California Department of Education, Child Development Division, 5601 Street, Suite 220, Sacramento, CA 95814. (916) 322-6233.

October 21-24: The 4th International Conference on Children Exposed to Family Violence, San Diego. Contact Hilary at the YMCA, (619) 239-0355.

October 23-26: Child Care Food Program Conference: Taking Care of Business, Oakland. Contact Magda McDonald or CCFP, (415) 276-2942.

CHP breaks new ground

(continued from page 1)

areas of further collaboration and funding avenues possible to support an ongoing child care health consultant service. Each county developed its list of priorities for further collaboration, and expanded the circle of key stakeholders who could advocate for continued funding and work to ensure continuity within the political framework of their county. Overall, many lessons were learned and actions initiated to bring the health and child care communities together.

The grant period runs from April of 1998 to March of 2000; we will update you throughout the coming year. For more information about this project, contact Lyn Dailey at (510) 281-7907. ✣

Ringworm

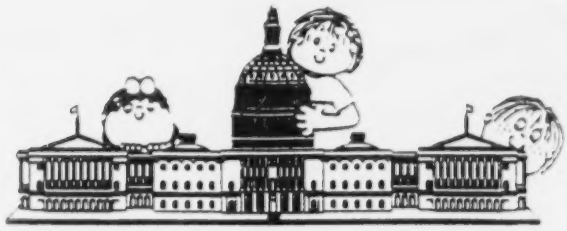
(continued from page 4)

- Have pets with skin rashes evaluated by a veterinarian. If the pet's rash is caused by fungus, don't allow children to come in contact with the pet until the rash has been treated, healed, and the pet has been bathed.
- Make sure children and providers wash their hands properly after contact with any animal, its belongings or cage.
- Do not allow children to share personal items such as combs, brushes, blankets, pillows, hats or clothing.
- Make sure that each child has his/her own crib or mat and does not switch.
- Keep sandboxes covered when not in use to prevent pets from using them.
- Refer persons with a suspicious rash or skin lesion to their health care provider for appropriate diagnosis and treatment.
- Keep any skin lesion covered, if possible.
- Keep the child care environment as clean and cool as possible.

To get a copy of the Health & Safety Note on "Pets in the Child Care Setting," call the Healthline at (800) 333-3212. ✣

Legislative update

by Marsha Sherman, CCHP Director



The two legislative bills described in our last newsletter which are a priority for the Child Care Health Program are AB212 (Aroner), the **California CARES** bill, and AB561 (Romero), the **Child Care Health Linkages** bill. Thanks to the many terrific supporters throughout the state, both bills have been approved by the Assembly!

We now need to focus our attention on getting these bills through the Senate. Please *write your California Senators* and tell them how important it is for them to vote for (1) AB212, the "Worthy Wages" bill for child care providers who study and stay in the field, and (2) AB561 to establish an infrastructure to assure that health and safety information, services and resources reach the children and families in child care.

It is only through your support with phone calls, letters and faxes that we can pass legislation needed to promote quality child care for all children in California. For a copy of these two bills, go to California Government Web site at **www.sen.ca.gov**, where you can also check a bill's progress, find out when it will be presented to committees and more. ✣

CPSC unveils Kidd Safety Web site

The U.S. Consumer Product Safety Commission (CPSC) unveiled a new and improved "Kidd Safety" web site at the New York City Toy Fair earlier this year.

Located at **www.cpsc.gov/kids/kidsafety/index.html**, the Web site is designed to educate children ages 8 to 12 about safety issues that they encounter every day, from hazards around the home to preventing injuries while playing sports. Using educational, interactive and fun activities, the Web site teaches kids how to be safe in their homes. The site combines a fun-loving character named Kidd Safety, with animation and sound to convey CPSC's messages of safety to children.

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Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Child-Proofing Your Home: 12 Safety Devices to Protect Your Children is a free publication by the US Consumer Product Safety Commission. This colorful brochure gives special emphasis to safeguarding children up to 5 years old. Call (888) 878-3246 to order up to 50 copies or print from the CPSC web site at **www.cpsc.gov/** in the What's Happening Section.

Product recall Information. For information about children's safety and recall of children's toys and products call CPSC's toll-free hotline (800) 638-2772. To get all CPSC recall information sent directly to you by fax, send your name and fax number to (301) 504-0399. For e-mail, send a message to listproc *a* cpsc gov and in the message area, enter: join CPSCINFO-L (no subject required).

KIDS COUNT 1999, a national and state-by-state profile of the status of children in the United States is now available from The Annie E. Casey Foundation, 701 St. Paul St. Baltimore, MD 21202. Phone (410) 547-6600, fax: (410) 547-6624, Web site: **www.aecf.org**.

Setting An Example from Child Trends is a report about how parents' health habits, physical health, levels of stress, negative feelings, access to health care, etc. affect their children's health. For a summary of the report and ordering information, visit **www.childtrends.org/example.**

"Sunny Days, Healthy Ways" is a free resource available from AMC Cancer Research Center to educate people about skin protection from sun exposure. Call (800) 525-3777 for a copy.

Spanish Heath & Safety Note available from the California Child Care Health Program

Bocadillos Saludables Para Niños Pequeños y de Edad Pre-Escolar (Healthy Snacks for Toddlers and Preschoolers)

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Celebrate Child Health Month and help California children

by Betty Z. Bassoff, DSW

October is National Child Health Month, a time to review and reflect upon the state of our children's health. Data from the latest *Kids Count*, a book published by the Annie E. Casey Foundation, show California children's health indicators to be up in some aspects and down in others.

For example, we still have too many low-weight newborns, but the infant mortality rate has improved greatly through better and early prenatal care. We've done well on increasing the immunization rate of young children and on reducing the child death rate (ages 1 to 14), but too many of our children still live in poverty (24 percent), with all of its implications for poor health.

If children need access to health services to stay well and help them recover when they are ill, then our most pressing problem is lack of health insurance. As of 1998, 19 percent of California's children were uninsured, a higher rate than in the rest of the United States (15 percent). No, these were not "welfare" families; 86 percent of the parents were in the workforce. The main reason: Fewer people in California receive job-related insurance than in the rest of the country.

What can you do as a child care provider? Review the medical records of children in your care. Do they have a regular source of health care? Find out where to refer families for health service programs in your area. If you don't know where to call, ask our Healthline consultants by calling (800) 333-3212.

Prepare now for Child Health Month by making September the month when you help all of the children in your care find a source of health care to keep them well and heal them when they're ill. ❖

Inclusion comes to the Child Development Division Conference in a big way

Mark your calendar now!

The California Department of Education Child Development Division Conference will be held at the Anaheim Marriott Hotel from Sept. 21-23, 1999.

There will be a full-day pre-conference institute: *Let's Make It Happen: Inclusion of Children with Disabilities in Child Care Programs*, and workshops on inclusion throughout the conference. CCHP staff will be presenting a number of workshops. Come see us and bring your Healthline questions!

For more information about the CDD Conference, call the Healthline at (800) 333-3212 or the California Department of Education, Child Development Division at (916) 445-1069.

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Explaining differences to children 8
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Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

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Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH

QUESTION:

I work at an after-school child care program and recently overheard an interesting conversation between a parent and her daughter. The parent was telling the child she could not play at her friend's house because her parents kept a gun in the home. Do you think it would be helpful to start a dialogue with staff, parents and children on the subject of guns?

ANSWER:

Firearms, particularly handguns in the home, have now become a major health hazard in America. Every year, hundreds of American children are killed or injured in unintentional shootings. In fact, the rate of unintentional firearm deaths of children is nine times higher in the United States than in 25 other industrialized countries (including Australia, France, Israel, Canada, Germany and England) combined.

Handguns are the most common type of firearm involved in gunshot deaths in the home whether accidental or intentional. Guns kept loaded and within reach for protection are often accessible to curious young children who unintentionally shoot themselves or others. The John Hopkins Center for Gun Policy and Research reports that the most common reason given for owning a handgun is protection from crime, yet only a small percentage of firearm deaths in the home are the result of an incident requiring self-protection. Studies also show that only 51 percent of adults in one-handgun households store their gun safely.

As a child care provider, injury prevention and safety awareness are always an important part of your work. Knowing the risks and dangers associated with gun ownership and sharing this knowledge with friends, parents and co-workers may help prevent another child from becoming the victim of an unintentional shooting.

Here are some suggestions to consider when initiating a dialogue on gun awareness:

1. Organize a parent meeting around the topics of guns in the homes and/or violence and the media. Be prepared for differences of opinion, and always consider the context of the community in which you are working.
2. Call the Bell Campaign at (800) RINGING (746-4464). This is a national grassroots organization dedicated to advocating against gun violence. They provide telephone consultation and also distribute free literature.
3. Talk to children honestly and in an age-appropriate manner about stories they have heard regarding guns and/or violence.
4. Call the Healthline at (800) 333-3212 to learn more about injury prevention in children's settings.

Infant/toddler issues

Infants, toddlers and violence

by Cheryl Oku, Infant Toddler Specialist

Violence touches the life of every child. Young children are exposed to violence in countless ways: from viewing media violence to playing with toys and games which promote violence, from overhearing second-hand reports of violence and warnings by parents about personal safety, to being harmed or abused, or witnessing acts of violence in the community or at home. In addition, infants and toddlers are highly sensitive to their parents' and caregivers' fears and reactions to violence.

We used to think that children under age 3 did not understand or wouldn't remember what they saw, heard and felt. However, recent brain research has shown how exposure to violence or chronically stressful environments can change the way an infant's brain develops, making the child more prone to emotional disturbances and less able to learn. Unpredictable, chaotic or traumatic experiences overactivate the neural pathways that control the fear response, causing children's brains to be organized for survival in a persistently threatening and violent world. The result is that such children live life on high alert, overly quick to interpret other's actions as threatening, and quick to respond aggressively in their own defense.

Children exposed to severe stress frequently develop learning disabilities and emotional behavioral problems (e.g. attention deficits, anxiety, depression) and appear to be at risk for a host of medical problems such as asthma, immune system dysfunction and heart disease.

There is hope, and there are ways to protect children. Although high-quality child care cannot counteract all the destructive effects of violence, positive early care experiences and warm, nurturing relationships are known to be critical contributors to children's ability to cope with stress and trauma. Research indicates that up to 80 percent of children exposed to powerful stressors do not sustain developmental damage when there are certain protective factors in the child's life. Here are some ways we can promote resilience as caregivers of infants and toddlers:

- Provide a stable emotional relationship with at least one significant adult (e.g. primary caregiver) who provides warm, sensitive and responsive care.
- Provide an organized and predictable environment.
- Address violence prevention by teaching skills to respect diversity and solve conflicts constructively.
- Reduce "disciplinary" violence by using and teaching other techniques.
- Help parents manage the stress of raising children by providing support and information.
- Educate parents about the importance of early experiences and the profound effects of violence on children.
- Collaborate with families to help reduce and cope with violence in the community.

Sources:

Starting Smart: How Early Experiences Affect Brain Development, by Theresa Hawley. Ounce of Prevention and Zero to Three, Washington, DC, 1998.

NAEYC Position Statement of Violence in the Lives of Children. NAEYC, Washington, DC, 1996.

Caring for Infants and Toddlers in Violent Environments: Hurt, Healing and Hope. Joy D. Osofsky and Emily Fenichel, Editors. Zero to Three, Washington, DC, 1994. ❖

Evaluate fire safety in your program

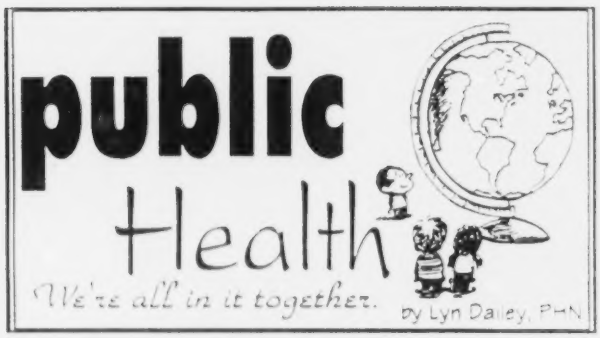
by Gail D. Gonzalez, RN

October 3-9 is Fire Safety Week. Most of us in child care have already had our facilities and homes inspected and approved as "fire safe." Fire extinguishers and batteries are changed and your emergency plan is filled out and posted. Employees are alerted to the evacuation procedure and route.

Here are some observations I've made when visiting child care programs which you may not have considered.

- All exits must be kept clear at all times—even during naptime. The rooms occupied by children must have unobstructed access to exit doors. I tell people to be careful where they place mats or cots for naptime, and where they leave the portable sand table when they're not outside. In and around a doorway is a tempting place to store or stack things. Don't give in to temptation. We never know when an emergency will happen, so even "temporary" blocking of an exit could be disastrous.
- Your evacuation route probably takes you the required 50 feet from the building, but is that the *best* route for you and the children? Will you be in the way of approaching emergency vehicles? Will the children be outside the fence and hard to keep together? Do you have to cross hot pavement, or is the route routinely littered with glass and debris?

(continued on page 11)



Communicating health, safety and developmental concerns to parents

Child Care Health Consultants often find caregivers very receptive to training on health and safety policies and procedures. However, providers frequently express the difficulties they experience when they try to enforce their policies, or parents do not follow through on health and safety recommendations. A common example that illustrates this dilemma would be the parent who does not follow the agreed-upon toilet learning plan when the child is at home. The key to successful parent-provider communication around "problematic" behaviors, illness management, or suspected developmental delays actually begins long before the concern arises.

Respectful, open, honest and productive communication doesn't happen by accident. You can set the stage by talking with parents about your health and safety policies before you enroll children. Discuss your philosophy about illness and child development, and explain what you do to keep your program as healthy and safe as possible. Be sure you let parents know that infants and young children will get sick more often than they did before they entered child care or switched programs. Explain why and when you exclude children for illness and what you will expect from parents. Keep parents fully informed about their child's activities and accomplishments, as well as any difficulties they seem to be experiencing. Parents will learn to trust your concern and judgment if they feel you have a deep understanding of their child's needs and desires. Your consistency and honesty will help them feel comfortable sharing their concerns as well.

Children do not spend up to 10 hours a day in your program to receive supervision only; they come to you for love, nurturing and care which enhances their development. Since children learn and grow by developing trusting, caring relationships with responsive child care providers, it is very important to prevent interference with that relationship. Parents need to support the practices you use to safely care for their child in order to prevent a strain in the relationship you have with that child. Seen in this way, the problem is not the child, but rather the lack of support you are receiving from the parents. Enlist the parents' support to help keep the special bond you have with their child—and be sure they are included in the development of any plans involving their child. Focus on strengthening the positive aspects of a child's development.

You can always practice uncomfortable conversations with our Healthline nurses or other specialists, and they can send you helpful support materials to reinforce your message. Basically, don't wait until you are frustrated or angry with a parent before you talk about concerns. If you have policies that make sense and are based on current health and safety recommendations, you will feel more confident enforcing them. Be consistent with *all* of your policies no matter how minor they seem; that way you and parents have a track record of successful expectations to build upon. Everyone benefits, especially the child. ❖

Messages to prevent tooth decay

by Andrea Azevedo

Dental decay (caries) is the most prevalent chronic childhood disease. The good news is, dental decay is preventable! Here are some important messages to prevent tooth decay.

Dental sealants

Fact: Sealants are thin plastic coatings painted on the chewing surfaces of the molars (the back teeth) to prevent decay. Sealants can prevent more than 80 percent of dental decay in children and reduce the need for fillings and other more expensive treatment. Dental sealants are applied by dentists or dental hygienists. Denti-Cal, Healthy Families and most private insurance programs pay for dental sealants.

Message: Suggest that parents ask their dentist about sealants for their children. If the family income is below 250 percent of the federal poverty level (for example, $41,750 for a family of four) refer them to Healthy Families or Medi-Cal to help cover the costs.

Fluoride

Fact: Fluoride protects teeth from tooth decay. Fluoride is available in toothpaste and in supplements (drops and tablets), may be topically applied by a dental health professional and may be found in the drinking water of some cities.

(continued on page 9)

Lead poisoning: What every child care provider should know

Because you care for young children, you should know how to protect them from the most common environmental disease—childhood lead poisoning.

Who is at risk for lead poisoning?

All young children are at risk for lead poisoning. They explore their environment by putting their toys, hands and other objects in their mouths. In addition, they spend a lot of time on the floor where sources of lead are likely to be found. Through normal play, they are likely to eat lead that has come from deteriorating paint, paint chips or dust. Young children also absorb more of the lead they eat than older children or adults. Children's rapidly developing bodies and brains are more vulnerable to lead's toxic effects than that of adults. Lead can limit a child's intellectual and physical development.

How do you know if a child is lead poisoned?

Most children with lead poisoning do not look or act sick. The only way to know if children are being poisoned is by testing their blood. Blood lead tests should be a part of well child checkups for children at 1 and 2 years of age. Parents may need to ask their health care provider for the test. Children between the ages of 1 and 6 years who have never been tested for lead should also be tested. This is especially important if they spend significant time in older homes or public places with deteriorating paint. Your doctor or Health Department will provide you with information on testing. Parents should call their health care provider or the Child Health and Disability Prevention Program at their local health department for more information.

What are the sources of lead poisoning?

Lead-based house paint and lead in soil are very common sources of childhood lead poisoning in California. The Federal Consumer Product Safety Commission limited the amount of lead in paint in 1978. Houses built or painted before 1978 may contain enough leaded paint to be of concern, and houses built before 1950 are very likely to contain high levels of lead in the paint. Leaded paint breaks down over time into dust or chips that can end up on toys, floors and in yard soil. When children mouth these things, they can become poisoned by the lead in the dust or paint chips. Soil may contain lead from peeling or flaking paint near the outside of old houses, or from leaded gas emissions, especially near busy roads.

Additional sources

- Lead brought home on clothes by persons working in lead-related industries
- Home remedies such as Azarcon, Greta, and Pay-loo-ah
- Handmade or imported pottery and dishes
- Hobbies such as making stained glass or fish sinkers/weights
- Some imported candy wrappers and imported food cans with lead-soldered seams

***Note**: In California, water is not a common source of lead poisoning.*

❖

What you can do as a provider to protect children in your care

- Make sure your own facility does not expose children.
- Promote health habits that will reduce the possibility of exposure.
- Teach parents what you have learned about childhood lead poisoning.
- Request children be tested for lead as part of their pre-admission health checkup if they are between 1 and 6 years of age and have never been tested before.
- Post information about childhood lead poisoning in your program.

For more information

- Call the California Child Care Healthline at (800) 333-3212.
- Call the lead poisoning prevention program of your local Health Department and ask for: (1) *advice* on testing your child care environment for lead, (2) *suggestions and resources* for reducing lead in your facility, and (3) *where to refer parents* to get their children tested for lead poisoning.

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HEALTH & SAFETY NOTES

California Child Care Health Program

HEAD LICE: A COMMON PROBLEM

Head lice are an extremely common problem, yet there is no surefire cure. There are effective treatments out there, but the real solution lies in cooperation. Child care providers and parents can form an effective team to prevent the spread of lice by establishing sensible policies and respecting those policies. ***Don't panic! Learn more about lice and act!***

What are head lice? Head lice are insects that live on the human scalp and feed on blood by biting the scalp. This biting causes intense itching. Head lice do not jump or fly, and they do not live on pets or animals other than humans. They lay eggs (nits) which attach to the hair shaft and hatch in about 6 to 10 days.

Who gets head lice? Anyone can get head lice. Young children are particularly at risk because the school or child care environment provides many opportunities to pass lice from one person to another, no matter how clean the environment is.

How are head lice spread? Since they don't jump or fly, lice must crawl from one person or object to another. This happens when heads touch (sleeping together, hugging, playing), or personal items are shared (combs, brushes, hats, carseats, bedding).

How are head lice diagnosed? Diagnosis is usually made by finding nits attached to the hair near the scalp. Scratching or scratch marks on the scalp, behind the ears, or on the nape of the neck may be a good clue.

How are head lice treated? Treatment involves getting rid of the lice and nits from the infected people, environment and personal items. Nits must be killed to prevent them from hatching. Individuals must be reinspected to prevent reinfestation from missed nits.

How can you help prevent the spread of head lice? Teach children not to share personal items such as hats, combs, brushes, hair ribbons, scarves, towels or bedding. Place items in children's cubbies so that coats and clothing do not touch. Inspect children's heads regularly for lice or nits.

When can a child return to child care? Be sure you know the program's policy. Treatment is usually required; the removal of nits will also likely be a requirement.

IF YOU HAVE HEAD LICE IN YOUR PROGRAM AGAIN

Get a handle on the real problem.
Detection and treatment, while important, are not the only aspects of effective head lice control. In fact, a lot of the frustration of dealing with head lice comes from policies that don't get to the heart of the problem, or poor communication between all of the parties involved. Education and cooperation must be an ongoing and routine part of your child care program if you truly want to minimize the problem.

■ **Develop a clear written policy.** Consider a "nit-free" policy. This means that there must be **no** nits present in the hair, dead or alive. This way you don't have to determine whether or not the nits are actually dead. You'll never control an outbreak if live nits return to your child care. At the very least, children should be excluded from care until after treatment has been initiated or there are no nits present.

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California Child Care Health Program • 1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

(Head Lice Continued)

■ **Communicate your policy with families and staff.** Make sure everyone understands what the policy means and how it will be enforced. Make this a part of enrollment procedures. Head lice are a special condition and require special attention, so be sure to address it separately from other illness exclusion policies.

■ **Make "head checks" a daily or weekly activity.** Create a special game or activity that allows staff to examine each and every child's head for lice. Friday afternoon is a good time so that families can treat and nit-pick over the weekend. Monday mornings are good so that staff can send infested children home before the lice spreads to others. Making this part of your routine helps avoid singling out children who may feel self-conscious about head lice.

■ **Include head lice as a topic for parent/staff meetings and newsletters.** Regularly engage parents and staff in discussions about identifying and treating head lice. Do this routinely, not just when there is a case in the child care. This allows everyone to express their fears, concerns, successes and failures in a safe environment. Assure that families and staff understand the importance of identifying cases early and carefully treating the entire family, house or facility.

■ **Do everything within your power to make head lice non-threatening.** You'll get much more cooperation from people if staff, children and parents feel like they are all a part of the solution rather than the source of the problem. Keep the issue a priority and celebrate your successes. Encourage sharing of ideas and information. Keep in contact with your county health department to find out about new treatment products or educational materials.

■ **Support one another**. Staff can offer moral support to families having a particularly difficult time treating a case. Treatment can be expensive and time consuming. Families may need extra assistance in meeting your policy requirements. Help one another problem solve. Call the Healthline at 800-333-3212 if you need additional information or materials.

■ **Teach and practice healthy habits for children.** Teach children not to share personal items such as hats, combs, brushes, hair ribbons, scarves, towels or bedding. Space children's cubbies so that coats and clothing do not touch.

A Few Additional Points to Consider:

- Do not use shampoos which contain conditioners **before** treatment because they can coat the hair and protect the nit. Do not use a vinegar rinse **after** using medications because it can deactivate the chemicals and reduce the effectiveness of the treatment.
- Treat children at the sink - **not** in the shower or bathtub - to minimize body contact with the pesticides in the medications.
- **Remember that none of the chemical treatments are 100% effective in killing lice and nits.** Removal by hand and comb is essential. Retreatment may be needed on the 11th day after the first treatment. Check with your pediatrician before treating more than twice.
- Always follow medication instructions. Consult your pediatrician or pharmacist if you are pregnant or nursing. We do not recommend using products which contain lindane.
- Call the Healthline to discuss the use of alternative treatments.
- Wash all personal items and bedding in **hot** water and dry in a **hot** dryer. Vacuum non-washable items, furniture and car upholstery.
- Contact the National Pediculosis Association (NPA):1-800-446-4NPA, or the Child Care Healthline: 1-800-333-3212.

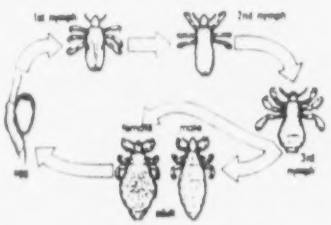

Figure 1. Life cycle of the head louse.

By Lyn Dailey, P.H.N. (Revised 12/98)

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Diversity

by Paula Gerstenblatt, M.S.W.

Explaining differences to children: a parent's perspective

As the white mother of two biracial children who resemble their black father, our family frequently encounters reactions from adults and children, such as stares or questions inquiring if I am the birth mother of my children, the adopted mother, or their mother at all. Often it is the presence of the parent the child least resembles that provokes these responses. If the child is transracially adopted and resembles neither parent, the issues are amplified. For parents of biracial/biethnic children, racial, ethnic and linguistic differences are a part of everyday life.

While pregnant with my son, I attended a preschool function for my daughter. One of her schoolmates came over and touched my protruding stomach. He then looked up at me with wide-eyed innocence and asked, "What color is this baby going to be?" Before I could respond, his mother chastised him for asking the question. As gently as I could, I explained that the question was perfectly logical and proceeded to answer: "Rena's father is black, I am white, so I think this baby will be the same color as Rena, but we won't know for sure until the baby is born." With that, the boy simply said, "Oh, okay," and ran off to join his friends.

This is my favorite example of how to talk to young children about racial and ethnic differences, honestly and age appropriately, never denying differences that are obvious to the child. Although a majority of my family's encounters were without malice, we have also experienced comments that provoked hurt feelings. If the remark was made by a child who attended the same child care program or school, I enlisted the support of the teacher, and if possible, the parents to foster an age-appropriate discussion which promoted tolerance and acceptance of differences. The critical factor in this process is the willingness of adults to face their own biases as a first step in assisting children.

When children have a strong sense of identity, they are better positioned to deal with other people's discomfort and well-intended curiosity. By working together, we can create a climate of change. When my daughter was born 17 years ago, there were few resources available for parents of biracial/biethnic children or those working with young children, to deal with issues related to diversity. Fortunately, times have changed with the development of a wide range of materials. Call me at the Childcare Health Program at (510) 281-7914 if you are interested in receiving additional information. ❖

Child passenger safety: What can child care providers do?

- Remember *all children must be in a child safety seat* until they are over 40 pounds in weight ***and*** over 4 years of age.
- *Make sure the child's size, the child safety seat size and the car all fit.*
- *Include child safety seat information during circle time.* Sing songs such as "The Wheels of the Car" and "This Is the Way We Ride."
- *Have a Safe Activity board.* Have pictures of children doing safe and unsafe things (carefully staged!). When asking the children about safety and unsafe situations, put the pictures on the floor and ask the children which are safe and unsafe. They can put the pictures on the board themselves.
- *Encourage children to be Buckle Up Buddies.* Buckle Up Buddies make sure that everyone is buckled up before the car starts and that everyone stays buckled up. This is a great game for children and their siblings at home, and helps get the message to parents, too.
- *Post the child safety seat law in your home or center.* Let parents know you're concerned about the safety of their children.
- *Sponsor a child safety seat training session with a qualified Child Passenger Safety Technician.* Invite your friends or colleagues to participate so that everyone is providing the safest care possible. Local and regional speakers are available through your Child Care Resource and Referral Agency or Health Department Child Passenger Safety Program, or call the California Child Care Health Program at (800) 333-3212 for help finding a local resource.
- *Include child safety seat information in your parent communications* (newsletters, meetings, flyers, etc.).
- *Encourage local media to do a public service announcement regarding Child Passenger Safety Awareness Week.*
- *Organize a fundraiser to purchase child safety seats* for use in your program or to be given to families in need (along with proper training).
- *Adopt an Auto Dealer.* Encourage the dealers in your community to use child safety seats when someone wants to test-drive a car if they have children along. Perhaps you could sponsor a fundraiser to send a dealer to a child passenger safety training class.

Reprinted from the CCHP Car Seat Curriculum: Safety on the Move

Inclusion insights

Collaborating for quality

by Pamm Shaw, Disabilities Specialist

In July 1998, a team of key stakeholders from across the state came together with initial support from the Federal Child Care Bureau to create the *California Map to Inclusive Child Care Project (MAP)* with a commitment to improve opportunities for children with disabilities and other special needs in child care.

The California Child Care Health Program and the California Department of Developmental Services—through its contract with the California Early Intervention Technical Assistance Network (CEITAN)/WestEd—in collaboration with and support from the California Department of Education/Child Development Division, provide staff to the project.

We have accomplished many things in the year since the MAP team first met. Some of the more tangible accomplishments include:

- Creation of a statewide team of key stakeholders
- Development of a strategic plan and statewide initiative
- Creation of an organizational structure to implement the strategic plan
- Participation in the National MAP Conference
- More than 25 statewide presentations and workshops on inclusive child care
- Dissemination of the *Bridges* newsletter on inclusion to 42,000 family child care providers, thanks to the Head Start Collaboration Office, CDE/Child Development Division and the Department of Social Services, Child Care Bureau
- Revision of the *Early Warning Signs* brochure through CDE/Special Education Division
- Development of a MAP video/slide show (for Fall 1999)

These activities were achieved because of individual and agency commitment to an identified vision, mission and goal. What have we learned from this collaboration?

- It takes time and hard work to build relationships.
- While we do not always agree, we come to the table to listen and be heard.
- We get to know and trust the team by learning about each other's systems, regulations, requirements, standards and acronyms.
- It's more fun to plan and present in teams—and it's less work individually.
- You have to ask questions to get answers.
- When people understand, they can learn to believe in a dream and make it a reality.
- Systems and people move in different ways, at different speeds and with different results, but they all move.
- Good food, comfortable chairs, an aesthetically pleasing environment and energetic, creative people help a lot.

If you have or know of inclusive programs that are working in your community and would like to share your story and experiences, please contact me at the Childcare Health Program at (510) 839-1243. ❖

Dental care

(continued from page 4)

Message: Find out from parents if their water at home is fluoridated. If not, suggest that they contact their child's dentist or doctor about a fluoride prescription.

Message: When a child reaches about age 2, caregivers can start helping children brush their teeth with a small drop (pea size amount) of fluoride toothpaste. Children up to about age 7 years will need adult help brushing their teeth.

Baby bottle tooth decay

Fact: This is a serious disease that destroys a child's upper front teeth. It can start as soon as the baby teeth come in. It is caused by letting babies and toddlers use a bottle too frequently.

Messages:

- Put babies down to sleep without a bottle. (If the baby goes to bed with a bottle, fill it with water only.)
- Around 6 months of age, let babies begin to drink from a cup.
- Do not give babies bottles filled with sweet drinks or milk to use as a pacifier.
- Near the first birthday, babies should only drink from a cup or breast, not a bottle.
- Breastfeeding is a good way to prevent baby bottle tooth decay.

(continued on page 10)

Incorrect car seat use can be deadly

by Vella Black-Roberts, RD, MPH

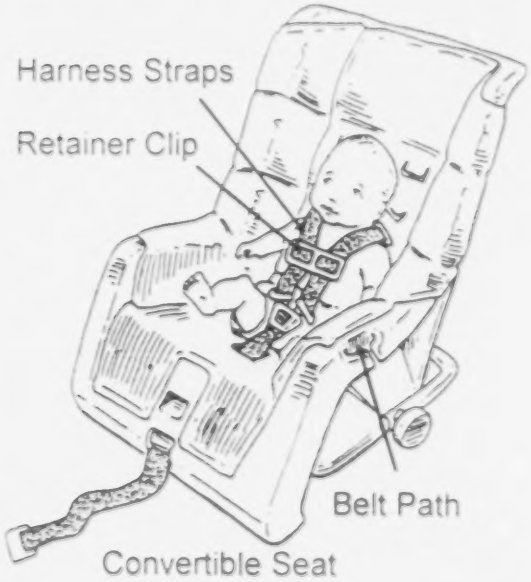
Recent studies conducted across the nation by the National Highway Traffic Safety Administration (NHTSA) revealed that more than 90 percent of car seats are being installed improperly. Traffic collisions are the No. 1 cause of death and injuries to young children, according to NHTSA. Certified Child Passenger Safety Technicians say parents need to know more about choosing the right child safety seat for their children. According to Cheryl Kim from Safety Belt Safe USA, "The 'best seat' is the one that fits your child, fits your car and fits your family needs in terms of comfort and convenience, so that you'll use it on every single ride."

Infants must be placed in car seats in a rear-facing position until they are at least 1 year old ***and*** weigh at least 20 pounds. This is to protect the spine, possibly preventing death or lifelong disability. Babies have heavy heads and weak necks with soft bones and stretchy ligaments. By placing them in a forward-facing position, the baby's neck may stretch up to two inches, but the spine can only stretch one-fourth of an inch. At about 1 year of age, the bones start to harden, and the baby gradually becomes less vulnerable. Finally, **infants must never ride in the front seat** if there is a passenger airbag. All children should ride in the back seat, which is the safest area inside the car.

Technicians and safety experts concur that to a large degree, the high misuse rates of child safety seats can be attributed to the difficulty in installing the seats and difficulty in reading and *following* instructions. For example, check for the following requirements, referring to the illustration at the bottom of the page:

- The **harness straps** need to lie flat on the child's shoulders. To make sure there is no slack in the shoulder harness, try to pinch a "tuck" in the strap to check it.
- The **retainer clip** should also lie flat against the child's chest at the armpit level.
- The child safety seat should be attached securely to the seat with a lap seat belt using the **belt path** on each side of the car seat. When the car seat is secure, it shouldn't move more than one inch forward toward the front of the vehicle or sideways.

To learn more about child passenger safety programs and how to install child safety seats, contact your local Health Department, Child Passenger Safety Coordinator or the Healthline at (800) 333-3212. ❖



Dental care

(continued from page 9)

Access to dental care

Fact: Many children who are eligible for dental insurance don't get it!

Message: Refer families to the Healthy Families Program at (800) 880-5305 and to the Denti-Cal Program's patient line at (800) 322-6384 for dental care for their children.

For more information on dental health, please contact Andrea Azevedo, BDS, MPH at (916) 654-9927 or Robert Bates, MD, MPH at (916) 657-3051. They are both at the Maternal and Child Health Branch of the California Department of Health Services. ❖

Product watch

Snugli Front & Back Pack™ soft infant carriers, models 075 and 080 are being recalled by Evenflo Company Inc. Small infants can shift to one side, slip through the leg openings and fall. Call Evenflo at (800) 398-8636 for instructions to exchange the carrier for a free, new carrier with smaller leg openings.

Cosco Inc. is recalling Arriva and Turnabout infant car seats/carriers manufactured between March 1, 1995 and Sept. 9, 1997. When used as an infant carrier, the handle locks on each side of the seat can unexpectedly release, causing the seat to flip forward and the infant to fall. For a free home repair kit to make the handle stronger, call Cosco at (800) 221-6736.

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Fire safety

(continued from page 3)

- Monthly drills are required because we know that children's knowledge is reinforced by practical experience and repetition. Consider these questions when having drills: Do the children hear the actual sound (not a substitute) which you want them to associate with evacuation? Are you and the children familiar with and able to demonstrate "Stop, Drop and Roll," "Hot Door Detective," "Crawl Like a Worm Under Smoke" and for earthquakes, "Duck 'n' Cover"? Can the children recognize a firefighter dressed in fire-protective gear? Does *everyone* know to evacuate *every* time the alarm rings (even when it's pulled by a child)?
- If you have to evacuate, will you have all the caregiving tools you need? All routines must be carried out even if you are evacuated and they all need some advance planning: supplies of food and water, necessities for diapering, toileting, medications, sunscreen, play activities and how you will notify parents of your status and location.

Planning tips and a resource list can be obtained from the Healthline. ❖

Health and safety calendar

September

September 21-23: 15th Annual California Child Development Conference, Anaheim. CA Department of Education, Child Development Division, 560 J Street, Suite 220, Sacramento, CA 95814. Call (916) 445-1069.

October

October 15-17: Family Child Care Association Conference, South Lake Tahoe. Contact OLDCA at (510) 658-7582.

October 17-19: CA Child Care Resource & Referral Network's Annual Conference, Pacific Grove. For information, contact Cindy Mall at (415) 882-0234.

October 21-24: The 4th International Conference on Children Exposed to Family Violence, San Diego. Contact Hilary at the YMCA, (619) 239-0355.

October 23-26: Child Care Food Program Conference: Taking Care of Business, Oakland. Contact Magda McDonald or CCFP (415) 276-2942.

October 25-27: Childhood Injury Control Conference, San Diego. Call the CA Center for Childhood Injury Prevention at (619) 594-3691.

Legislative update

by Marsha Sherman, CCHP Director

How do I find an approved preventive health practices class?

Many months ago legislation (AB1524) was passed requiring approval of the preventive health section of the Child Care Health and Safety Training (15-hour training). The first step to implement the legislation was for the Emergency Medical Services Authority (EMSA) to develop regulations for approval of training organizations. Effective Sept. 1, 1999, approval will be necessary to provide some quality assurance for the training. The EMSA already does that for CPR and First Aid curricula.

The process has not gone as smoothly as all of us would have liked, but it is moving along. If you enroll in a Child Care Preventive Health Practices class from a community college, state university or other accredited college, the course is considered an approved course. If you take the course from an individual or training organization after Sept. 1, 1999, look for one that is EMSA-approved. The trainer will be able to put a small sticker on the course card or other documentation to show it is an approved course. If you cannot find an approved course, wait until you do. *Do not take the course from anyone who is not approved or you will have to take it again.*

Community Care Licensing, EMSA, many trainers and CCHP are working together to establish practical regulations, assure sufficient training, and assist child care providers in finding appropriate training. For names of approved training organizations, please call EMSA at (916) 322-4336 or the Healthline at (800) 333-3212. ❖

Remember:

To reduce the risk of SIDS

- Place babies on their ***backs to sleep***
- Use a ***firm and flat surface for sleeping***
- Provide your baby with ***smoke-free*** surroundings
- Keep babies ***warm, not hot***
- Encourage regular ***checkups and immunizations***
- Encourage ***breastfeeding***

Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Childproofing Your Home is one of many free publications available from the U.S. Consumer Product Safety Commission (CPSC). To order, call (888) 878-3256 or visit **www.cpsc.gov/**.

Reducing the Risk of SIDS: A Community Outreach Curriculum is a redesigned, educational outreach module for promotion of public awareness of Sudden Infant Death Syndrome (SIDS). To order a copy of the curriculum kit or additional SIDS materials please contact the California SIDS program at (800) 369-7437.

Clean and Healthy...Strategies for Today's Homes: Allergies and Asthma is a complete, ready-to-use education program for helping asthma and allergy sufferers. It's available free of charge to public health and community educators and non-profit organizations by contacting SDA at (212) 725-1262.

Online Resources

Food Guide Pyramid for Young Children released by the U.S. Dept of Agriculture is targeted to children ages 2 to 6 and offers healthy nutritional choices. The $5.00 booklet is available to the public on USDA's Center for Nutrition Policy and Promotion Internet home page at **www.usda.gov/cnpp** or through the Government Printing Office by calling (202) 512-1800 and asking for stock number 001-00004665-9.

What Works Learning Community at **www.wwlc.org** is designed to share policy ideas for improving child and family well being. On an interim basis, this is one of the two sites providing information on the California Children and Families First Initiative (Prop 10). Go to **www.children98.org** to find official postings of the State Children and Families Commission, including text of the initiative, minutes of meetings and legal advisory opinions.

Child Care Self-Assessment Guides for Child Care are now available online at the Department of Social Services Web site at **www.dss.cahwnet.gov/CCLD/docs/childcare/ccap.htm**.

American Head Lice Information & Resource Center at **www.headliceinfo.com** provides safe solutions and links to other head lice-related Web sites.

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A health and safety newsletter for California child care professionals

Published by the California Child Care Health Program
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November-December 1999 Volume 12, No. 6

Take action: Build a child care mental health consultant service in your community

by Marsha Sherman, MA, MFCC, Program Director

The California Child Care Health Program has been working since 1987 on issues linking children's health and the early childhood field. Throughout the state we most commonly hear teachers asking for "help caring for children with challenging behaviors." There seems to be at least one child in every program who drives child care providers crazy. It's not always the overly aggressive child, sometimes it's a non-communicative child who withdraws and won't participate. Sometimes a child cooperates, plays well and is a leader in the class, except for 10 minutes each day. But oh, those 10 minutes, as the child turns over the table where children are painting or sprays everyone with the fire extinguisher! Or you worry about the child because his/her behavior is different from the others, but you can't quite explain the "problem."

What help is available? Very little. Although many Head Start programs have mental health support services, few are available to child care programs. It's time to collaborate to create a system of mental health consultation with a consultant who can come to your program, meet with the providers/teachers, parents and observe the child of concern. The consultant can then assist in discussing the issues with parents and providers to arrive at a consistent plan to help the child. The consultant would provide help on activities, responses and policies to build on the child's strengths and help him feel secure and comfortable in his environment, and assist in establishing a child and/or family intervention plan if more is needed.

Funding mental health services is often expensive, and not all families and/or child care programs can afford such services. Few mental health providers have the training and/or experience to work with children in the preschool years. Yet early intervention could prevent more serious problems during the school years.

(continued on page 11)

HEALTH & SAFETY TIP

If a child in your facility has a seizure:

- Remain calm.
- Place the child on the floor and turn him/her on the left side to keep the airway clear.
- Place something flat and soft (e.g. palm of your hand or a folded towel) under his/her head.
- Move toys and furniture away to prevent further injuries.
- Wait until the seizure has finished. Time the seizure and let the child rest.
- Comfort other children who might be upset, and explain that the child will be all right.
- If the child's medical record indicates a history of seizures, call the parent.
- If the child has no history of seizures, or the seizure lasts more than 10 minutes, call 9-1-1 for emergency medical attention.
- The child's health care provider or parent should let you know how to respond to his/her seizures in the future.

Highlights of what's inside:

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Child Care Health Connections
November-December 1999
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Child Care Health Connections is a bimonthly newsletter published by the California Child Care Health Program, a nonprofit organization in the Graduate School of Public Health at San Diego State University. The mission of the Child Care Health Program is to provide current and emerging health and safety information relevant to child care providers and to link the health, safety and child care communities.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of $20 per year. ***Newsletter articles may be reprinted without permission*** if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Child Care Health Program at the San Diego address below.

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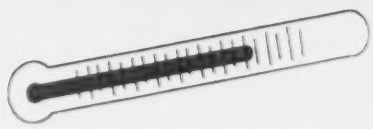
Information provided in Child Care Health Connections is intended to supplement, not replace, medical advice.

Visit our Web site at:
www.childcarehealth.org

Ask the nurse...

by Deborah Thompson, RN, MPH



QUESTION:

A child in our center recently was diagnosed and treated for scabies. Could you tell me more about it?

ANSWER:

Scabies is a parasitic disease of the skin caused by a mite. When the mite penetrates or burrows into the skin of a child or adult, you can see an itchy, raised and usually red rash and tiny lines containing the mites and their eggs. These itchy red lesions are often first seen around the finger webs, arms, waistline area and thighs of adults. In infants and children, the head, neck and palms of the hands or soles of the feet may be involved. The most common symptom of scabies is intense itching, especially at night.

Proper identification and diagnosis of scabies by a trained health professional is very important not only because scabies is a communicable disease, but because scabies can often be accompanied by bacterial infections and easily confused with other skin diseases. Diagnosis can be made by applying mineral oil on the affected area of the skin, lightly scraping it and examining the scrapings and any mites under a microscope. The human scabies mite infests and reproduces only on humans. Scabies mites from other animals may cause small local irritation but will not become an infestation.

Scabies is spread by skin-to-skin contact between people. Mites can also shed onto clothes, towels, pillows, bedding and furniture. Sharing infested items can increase the spread. Treatment of scabies is usually simple and effective once a diagnosis has been made. The National Pediculosis Association (NPA) strongly *discourages* the use of scabicides that contain the chemical lindane. While all scabicides are pesticides and must be used with caution, products containing topical 5 percent permethrin are considered safer treatments than products containing lindane.

Ways to limit the spread of a scabies infestation:

- Look for signs of scabies during the morning health check and refer suspected cases for evaluation and treatment.
- Send a notification letter immediately to parents and teachers about scabies and necessary precautions. (It can take four to six weeks to develop symptoms after exposure to live mites.)
- Launder clothes, towels and bedding in a machine with hot water and soap, and dry them in a hot dryer. Non-washable items should be dry-cleaned.
- Vacuum carpets and upholstered furniture.
- Separate personal clothes (e.g., jackets) and bedding into individual cubbies for each child.
- Children with scabies should be sent home from the program and may return the day after treatment is complete.

Infant and toddler issues

Talking with parents about illness

by Cheryl Oku, Infant Toddler Specialist

Parents often worry that their babies will get sick in child care. There are a number of ways that you can reassure them that you are taking all the precautions to minimize this situation.

Be sure to let parents know you are also concerned about their child's health and well-being by sharing these basic but important concepts:

Look at health as more than illness prevention. Children learn healthy habits through daily routines when you model healthy behaviors such as washing hands and covering your mouth when sneezing or eating nutritious snacks. As children develop, their health needs change and the environment and program should support the child's growth and well-being. For example, when infants begin to crawl, they need to explore toys and surfaces which have been cleaned and sanitized regularly and are safe.

You help prevent illness and health problems in many ways:

- You screen for health problems, including daily health checks, by keeping health records and making sure immunizations are up to date.
- Your diapering and toileting practices are hygienic.
- Sleep and rest take place in clean, quiet and personal spaces.
- Meals and snacks provide appropriate nutrition and support the development of self-help skills.
- Health policies clearly state when children are to be excluded from child care.
- Adults practice and model healthy behavior, good personal grooming, hygiene and a positive mental attitude.
- The environment is regularly checked for health and safety hazards.
- Toys and surfaces used by children are cleaned and disinfected regularly.
- Indoor spaces are well lit and ventilated.
- Children have regular opportunities to play outdoors.
- Children with special health needs have current care plans on file and staff are trained on their use.

Children will get sick. Between the ages of 1 and 3 years, children typically get sick five to 12 times a year, whether they are in child care or not, but group care increases the number. While many illnesses and conditions should exclude a child from child care, many others can be mild and are already spread to others before symptoms appear (such as colds and hand-foot-and-mouth disease).

Sick children will need your comfort, concern and knowledge of good health practices. Decide whether you are prepared to care for a mildly ill child and to give medication if needed. Develop, communicate and enforce health policies listing specific symptoms for exclusion, such as vomiting, uncontrolled diarrhea or undiagnosed rashes.

Ask parents at the time of enrollment to plan ahead for alternate care when their child is too ill to be in your program. Try to understand that parents may have mixed feelings about leaving their child, and illness will magnify any guilty feelings.

Keeping children healthy requires a team effort! Listen to parent concerns, take time each day to note health changes or concerns and share health information. Build trusting and respectful relationships with parents over health issues to enhance the quality of care you give infants and toddlers. ❖

Welcome CCHP's new child care mental health consultant

CCHP staff welcomes new child care Mental Health Consultant, Jennifer Smith. Jennifer is bilingual in Spanish and holds a Master's degree from San Francisco State University in Developmental Psychology. Her background includes experience in the field of early intervention, both with the Regional Center as well as with family education and home visiting services. She has also worked in several infant/toddler and preschool programs. Her primary focus has been work with children up to age 5, specifically with issues of attachment and bonding.

She will be working on the Child Care Mental Health Project to pilot child care mental health consultation services to child care programs within Alameda, Stanislaus and Ventura counties. In addition, her duties will include responding to Healthline requests for information on behavior, child abuse, violence prevention, accessing services in the community and other mental health and behavior related issues. She will also represent CCHP at statewide policy meetings, training workshops and conferences and developing written materials to assist child care providers, families and mental health providers to link with one another.

HIV/AIDS in child care

by Lyn Dailey, RN, BSN

Dec. 1 is World AIDS Day. Worldwide there are more than 1 million children under age 15 years living with HIV/AIDS. In California, 214 children were living with HIV/AIDS as of May 31, 1999. The vast majority of children were infected while in the womb, during birth or through breastfeeding. This means that children living with HIV/AIDS most likely have a mother who is living with or has died from AIDS. Some of these children will develop serious signs and symptoms in their first two years of life. A larger group will progress more slowly and may not become severely ill until they are seven or eight years of age. A few will stay healthy even longer.

What does this mean for child care programs? First, the likelihood is small that you will care for an HIV-positive child. Second, because families do *not* have to tell you about their child's HIV status, you may never know if you are caring for a child who is infected. Third, if you *do* know that a child is HIV positive, it may mean that the family is under the emotional strain of one or both parents also being infected.

Knowing that a child has HIV infection doesn't protect anyone—practicing Universal Precautions does.

- Always wear latex (or equivalent) disposable gloves when handling any body fluids containing blood, and wash your hands immediately after removing gloves.
- Know which job tasks might expose you to blood, such as first aid or changing bloody diapers or bandages.
- Dispose of waste containing blood in a manner that prevents others from coming into contact with it (this includes the lancets or sharp, pointed blade used to perform finger sticks for blood sugar monitoring).

Many families want their child care provider to know that their child has HIV/AIDS so that their care can be individualized. Seek the help and guidance you need to provide the safest care possible for *all* children, including those with special medical needs. Honor a family's right to confidentiality, and help them if they decide they would like to share this information with other staff or families in the program.

> ***"Knowing that a child has HIV infection doesn't protect anyone—practicing Universal Precautions does."***

Observe World AIDS Day:

- Inform yourself, your staff and your families about preventing HIV infection and the realities of living with HIV/AIDS. Speakers are available in most communities.
- Gather information on available resources and train staff in Universal Precautions.
- Call the Healthline if you need written materials or have questions. ❖

Study finds link between quality child care and child development

by Betty Z. Bassoff, DSW

Important study results have recently been released by the National Institute of Child Health and Development in Washington, D.C. The four-year study of early center-based child care, conducted in nine states, focused on a single question: *Do children perform better in terms of cognition, language and social competence (outcomes) when they receive child care that meets professional standards for quality?*

The measures used were standards for child-care staff ratios, caregiver training and caregiver education. Model standards against which the research data were measured were drawn from the 1992 national guidelines created by the American Academy of Pediatrics and the American Public Health Association, *Caring for Our Children*.

Although all states regulate child care, standards vary greatly—for example, from a child-staff ratio of 3:1 to 12:1 for infants. California standards are among the best, employing a 4:1 ratio for infants. Requirements for training and education rank further down the scale.

What did they learn? First, most classes observed did not meet all four recommended standards. Second, a direct relationship was found to exist between standards met and outcomes for children. Third, children in classes that met more standards had better school readiness and language comprehension scores as well as fewer

(continued on page 11)

Playground safety

by Rahman Zaman, MPH

Use of playground equipment is the leading cause of injuries to children. Each year more than 90,000 children under 6 years of age receive emergency room care for playground-related injuries. In 1997 about 31,000 children 4 years old and younger were treated in emergency rooms for injuries at child care/school settings. Most of these injuries are preventable.

Though many child care settings provide a safe environment for young children, 24 percent of child care settings didn't have safe playground surfacing and 27 percent did not keep the surfacing well maintained, as indicated by the recent Consumer Product Safety Commission's (CPSC) study of safety hazards in child care settings. A 1998-1999 survey by the National Program for Playground Safety (NPPS) also indicated that child care, school and park playgrounds are deficient in supervision, age-appropriateness of equipment, suitable fall surface and equipment maintenance. Based on the findings of the survey, NPPS developed a national action plan focusing on those four areas of playground injury prevention.

The following **S-A-F-E** tool will help you remember the four most important points for maintaining playground safety.

Supervision: Adult supervision can help prevent injuries by not allowing unsafe behavior and improper use of playground equipment. Watch for potential hazards such as broken glass or pieces of metal before allowing children on the equipment, observe children playing and be available in case an emergency occurs.

Age-Appropriate equipment: Since children are developmentally different, play areas for preschool children (ages 2 to 5 years) should be separated from school children (5 to 12 years). Direct children to play on equipment that is appropriate for their age and level of ability.

Fall Surfaces: The surface under and around the playground equipment where a child might fall (fall zone) must be soft enough to absorb the shock of falls. Hard surfaces such as asphalt, concrete, grass, packed dirt or rocks are not appropriate. Wood chips or mulch, sand, pea gravel, rubber and rubber-like materials that can protect children when they fall are acceptable alternatives. Make sure that surface materials are at least 12 inches deep and cover the fall zone.

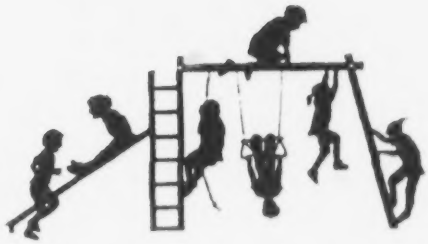
Equipment: All equipment needs periodic checks and maintenance. Verify that equipment is safely anchored to the ground and all pieces are in good working order. Disintegrated, broken or missing parts, or cracked and rusted equipment can create safety hazards. Peeling, lead-based paint can poison children.

For additional information on any aspect of playground design and safety, call (800) 554-PLAY. You can also call CPSC at (888) 878-3256 for information and publications, or visit their Web site at **www.cpsc.gov**. ❖

Sources:

The National Program for Playground Safety (NPPS)

Consumer Product Safety Commission (CPSC)



Playground safety tips

- Supervise children at play. Don't allow children to go beyond your range of direct supervision.
- Pay most attention to the high-risk play areas such as climbers, slides and swings.
- Develop three to five rules to be followed on the play-grounds.
- Be aware of conditions that contribute to injuries such as drawstrings that may strangle a child if caught on playground equipment.
- Don't let children wear bike helmets while playing on playground equipment.
- Make sure that equipment is age-appropriate.
- Confirm that the fall zone is covered with loose-fill surface material.
- Detect and remove poisonous plants, trash or sharp objects from the area surrounding the playground.
- Be certain that slides are enclosed or have handrails.
- Check equipment for sharp protrusions.
- Make sure that bolts are covered and swings have soft seats.
- Ensure that there are no spaces where a child's head, leg, or arm could be trapped (3-½ to 9 inches).
- Keep sandboxes covered when not in use.

HEALTH & SAFETY NOTES

California Child Care Health Program

GENERAL RECOMMENDATIONS FOR CLEANING, SANITIZING AND DISINFECTING IN THE CHILD CARE SETTING

Illnesses may be spread in various ways, such as by coughing, sneezing, direct skin-to-skin contact, and touching an object or surface with germs on it. Germs causing infection may be present in human waste (urine, stool) and body fluids (saliva, nasal discharge, draining lesions or injuries, eye discharges, vomit, and blood).

Infected persons may carry communicable diseases without having symptoms, and they may be contagious before they experience symptoms. Child care staff need to protect themselves and the children by routinely cleaning and disinfecting exposed areas. Gloves should be worn when cleaning up spills of body fluids, especially blood, and hands should be washed any time body fluids are touched.

- ***CLEAN AND SANITIZE.*** *Remove dirt and debris, e.g. blood, urine, vomit, stool, food, dust, or fingerprints by scrubbing and washing with detergent and water.* Routine cleaning with an all-purpose liquid detergent or abrasive cleanser and water gets rid of the dirt you can see in the child care setting. Scrubbing physically reduces the number of germs on surfaces (as when we wash our hands). Use a disposable cloth or one that can be washed after each use, so you don't move germs from one place to another. Sponges are never recommended.

What surfaces and items might you clean and sanitize?

- The table top *after* lunch or snack, paint or clay, manipulatives or books
- The floor *after* lunch
- Desks, bookcases, toy shelves, chairs, windows or sinks
- The kitchen sink after lunch
- The laundry
- Cots (weekly), cribs (daily), blocks, trucks, preschool floors, or cubbies when soiled

Some items and surfaces should receive an additional step, *disinfection*, to kill germs **after** cleaning with detergent and rinsing with clear water.

- ***DISINFECT.*** *Eliminate virtually all germs left on surfaces after cleaning through the use of chemicals, such as a germicide or chlorine, or a physical agent such as heat.* In the child care setting, a solution of 1/4 cup household liquid chlorine bleach added to 1 gallon of cool tap water (or 1 tablespoon bleach to 1 quart of water) prepared fresh daily is an effective disinfectant. Disinfecting with bleach is NEVER effective unless the surface has been thoroughly cleaned first. To avoid fumes, corrosion and color loss on surfaces and still gain effective disinfection, look for a commercial product which is a "quaternary ammonium" and dilute according to the label instructions.

California Child Care Health Program • 1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
Tel: (510) 839-1195 • Fax: (510) 839-0339 • Healthline: 1-800-333-3212

(General Recommendations for cleaning continued)

Some of the newer products have a detergent in them and can be used to clean and disinfect in one step **if** there is no gross contamination with food particles, meat juices, blood or dirt. If these are present, cleaning first is still required.

What might you need to clean and disinfect?

- The toilet seat if soiled, and the toilet at the end of each day
- The kitchen sink after raw meat or chicken has been rinsed, and at the end of each day
- The diaper changing table if wet or soiled, and at the end of each day
- Table tops ***always*** before meals; food preparation surfaces before setting food out
- Toys which are mouthed
- Crib rails at the end of each day

Items that can go through the dishwasher or washing machine cycle are disinfected if the water is hot enough to kill the germs (160°F).

- ***PROCEDURES.*** *Surfaces and objects which get daily use should be cleaned and disinfected at least once a day, and soon after contamination.* These items include diapering areas, toys (if the children are drooling and mouthing the toys), floors, table tops, toilets, and food preparation areas.

1 **TO CLEAN AND SANITIZE**: Scrub objects and surfaces with abrasive cleanser or detergent and water. Your surface is now clean and germs are somewhat reduced.

2 **TO DISINFECT:** Apply disinfectant solution by spraying from a spray bottle or by dipping the object into the solution. Allow object or surface to air dry before using it again.

- Hand-washed dishes must **always** be cleaned and disinfected after each use, using bleach water only. Other disinfectants should not be used for dishes or laundry.
- Washable cloth toys and other items can be machine-washed when contaminated, and machine heat-dried. They are effectively disinfected this way.
- Pacifiers and manipulatives can go in the dishwasher in a mesh bag on the upper level and heat dry to become disinfected.
- Carpeting should be vacuumed daily and shampooed at least every six months. *This must be done when children are not present to avoid fumes and allow the carpet to dry.*

NOTE: We urge our readers to obtain more comprehensive information on cleaning and disinfection from "Caring for Our Children" and from the CCHP *Prevention of Infectious Disease* Curriculum.

By Gail D. Gonzalez, R.N., Child Care Health Consultant
(August 16, 1999)

REFERENCES:

American Public Health Association and American Academy of Pediatrics, *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, Washington, D.C., 1992.

California Child Care Health Program • 1322 Webster Street, Suite 402 • Oakland, CA 94612-3218
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Ten tips that promote healthy brain development in children

Excerpted from the "Rethinking the Brain" presentation kit from Families and Work Institute, 1998

1. ***Be warm, loving and responsive.*** When children receive warm care, they are more likely to feel safe and secure with the adults who take care of them and become attached to them.

2. ***Respond to the child's cues and clues.*** Being responsive includes understanding what the child is saying and then responding. It may be responding to a child emotionally (when hurt), socially (getting along), or intellectually (bringing him a book about bugs when he has become fascinated with bugs).

3. ***Talk, sing, and read to children.*** It's not just reading a story, but reading a story in a way that gets a child to participate. It's not just listening to music, but singing to the child so he or she sings back.

4. ***Establish rituals and routines.*** Teach young children to know when it's time for bed by developing routines such as singing a song and pulling the curtains. Daily routines and rituals create memories children will have forever.

5. ***Encourage safe exploration and play.*** As infants grow, they begin to explore the world beyond their caregivers. Encourage this exploration. Children actually learn through playing.

6. ***Make television watching selective.*** Watch television with the child, and talk about what is being seen. Don't use TV as a baby-sitter.

7. ***Use discipline as an opportunity to teach.*** In addition to consistent and loving adult supervision, teach children limits. Never hit or shake a child.

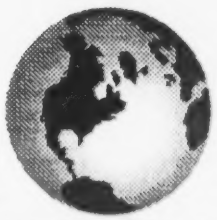
8. ***Recognize that each child is unique***, but expect children to succeed. Children grow at different rates. Their ideas and feelings about themselves reflect, in large measure, parents' and caregivers' attitudes toward them.

9. ***Choose quality child care and stay involved.*** Frequently visit child care providers and seek someone who responds warmly and responds to the children's needs.

10. ***Caregivers need to take care of themselves. They need nurturing too.*** When parents and caregivers are exhausted, irritable, depressed or overwhelmed, they may have a harder time meeting the needs of young children. ❖

*For more information, visit the Family and Work Institute's Web site at **www.familiesandwork.org***

Developing culturally sensitive relationships with families



by Paula Gerstenblatt

Working in a culturally diverse environment can be one of the most enriching aspects of being a child care provider. There is much to learn and share about other cultures that can be integrated into your program. This includes celebrating holidays, art, history and the diverse beliefs and practices of all families in your program. A crucial link to a successful multicultural program is developing strong relationships with families. Families possess a wealth of information and are your best resource.

Cultural diversity can also be one the most challenging aspects of your program. Building relationships across cultural lines first requires a clarification of your values and beliefs to prevent a potential obstacle in relating to families whose beliefs and practices differ from your own. Passing judgment, intentionally or unintentionally, is a significant roadblock to relationship building.

There are many ways to build relationships with family members. The initial interview is a great opportunity to gather information about the family, particularly information about cultural practices and beliefs. If you have questions, the best approach is to ask. This shows that you care about the family and are interested in their child. Invite family members to participate in activities and to lend their expertise in ways they feel comfortable. Consider that "family" is not limited to mother and father, it may include a grandmother, grandfather, aunt or uncle, so be sure to include them as well. Extend an invitation to family members to share their culture at parent meetings, in the classroom and other program-sponsored other events. Building culturally sensitive relationships honors the diversity of your program, demonstrates respect and validates the child's culture, thus strengthening his or her sense of self. For biracial/biethnic children, there is a need to acknowledge and be aware of the child's complete cultural background.

Building culturally sensitive relationships with families takes time. Some family members may be more receptive than others. Some may feel comfortable participating in program activities, while others would prefer to remain in the background. Relating to families in their cultural context helps you to understand the family and gauge your approach. Developing culturally sensitive relationships with families facilitates family involvement and provides information on how to serve the best interest of the child. ❖

Inclusion insights

Attention Deficit (Hyperactivity) Disorder and child care

by Pamm Shaw, MS, Coordinator, MAP to Inclusive Child Care

- ***"HELP! My child has been thrown out of the child care center. He has ADD."***
- ***"We have so many children with ADD. The medication wears off before they come to child care."***
- ***"Why do they qualify for special education services during the day, and yet we get no support in the after school program?"***

Calls to the Healthline from school-age child care providers most often have to do with children's behavior or how to access services and/or funding for children with AD/HD. Let's look closer at AD/HD.

What is AD/HD?

Attention Deficit Hyperactivity Disorder (AD/HD) is a condition that causes children to have trouble paying attention and to be overactive and impulsive. These behaviors often appear in early childhood and are not due to other physical, mental or emotional causes. About 20 percent of the children with AD/HD also have learning disabilities. Attention deficit disorder (ADD) can also occur without hyperactivity.

AD/HD affects about 3 to 5 percent of *all* school-age children. It is more common in boys and tends to run in families (e.g. "He's just like his father"). AD/HD affects *all* socioeconomic, cultural and racial groups. Research suggests that AD/HD is caused by a chemical imbalance or a lack of certain chemicals in the brain.

Treatments for AD/HD

Recent research points to the over-diagnosis and over-medication of children who exhibit "out of control" behaviors. Methylphenidate (Ritalin) is the most commonly prescribed medication for children with AD/HD. It does *not* work alone. A team approach among the family, school, child care, counselors and others is required to provide behavior and other appropriate interventions. Counseling, structure for school and social activities and family support are all critical to the success of children with AD/HD.

What you can do

Get a good diagnosis. A psychologist should assess the child's cognitive, attention, memory, learning style, and social-emotional development. A pediatrician or psychiatrist should be involved to determine if medication should be part of the treatment plan. Child care providers can observe and provide input into the assessment process. Professionals and other specialists can observe the child in more than just the academic setting. And parents are a critical part of the team.

A diagnosis of AD/HD does not automatically mean the child will have problems socially, academically or personally, though it does put him/her at higher risk. Children with AD/HD *may* be eligible for special education and related services. Children who do not qualify for special education but still need extra support may be eligible for "504 Accommodations." Parents should speak with the special education staff in their local school and request an evaluation. If a child qualifies for special education, an individualized education plan (IEP) will be developed. Be sure to ask the parents to have "consultation to the child care program" written into the plan. The plan should specify the services to be provided, how often and who is responsible. While it is often complicated and difficult to coordinate multiple agency services, it is very important that child care staff be considered part of the treatment team.

It is not always easy to care for children with AD/HD, but a team effort will make it easier. These children are a challenge, yet they can also be very bright, creative and energetic. Call the Healthline for more information, resources, or if you just want to talk about a child. ❖

CPSC study warns against placing babies in adult beds

The U.S. Consumer Product Safety Commission (CPSC) recently issued a warning to parents and caregivers about the dangers of placing babies to sleep in adult beds. The warning was issued based on a CPSC study published in the October issue of the *Archives of Pediatrics and Adolescent Medicine*.

The study revealed that an average of 64 deaths occur each year when babies under age 2 are placed to sleep in adult beds, including waterbeds and daybeds.

The January-February issue of *Child Care Health Connections* will address this issue in greater detail, evaluating the pros and cons as well as cultural issues that affect parents' decisions. ❖

Child car seat safety for children 1 year old and older

by Vella K. Black-Roberts, RD, MPH

Editor's note. *This is the second installment in a three-part series focusing on child safety seats.*

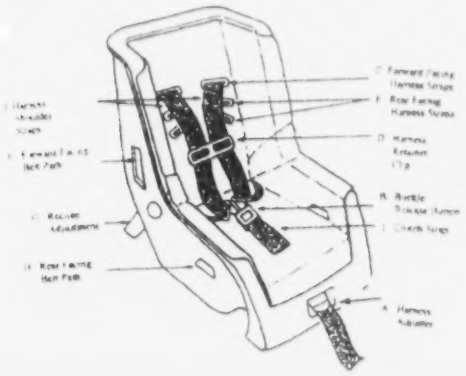
As children develop, they outgrow many things: clothes, toys, games, even child safety seats. Yes, car seats! In fact, a child's safety seat may be the most important item to consider as a child grows, yet it is often overlooked.

Keep using rear-facing seats as long as possible. Proper child seat safety requires monitoring a child's growth and fit in his/her child safety seat. A secure fit matters when ensuring safety. Age is also a factor. When children are 1 year old, they may ride in a forward facing safety seat for best protection. However, small toddlers should continue using a rear-facing seat as long as possible based on the weight limits described in the car seat instructions.

Convertible child safety seats accommodate growth. Convertible child safety seats are designed to adjust as a child grows to ensure the safest and best possible fit. Convertibles also come with three different restraint systems: a tray-shield, T-shield or five-point harness system. Child safety seat professionals recommend the five-point harness system because it offers the best fit.

Children transported in convertible seats should be facing forward with the seat in an upright position. In this position, the harness straps should be at or above the child's shoulders and inserted in the uppermost (not center) seat slots. It's important to make these adjustments according to the manufacturer instructions to prevent possible serious injuries to the child. The vehicle seat belt path should also be moved from the front to the back of the child safety seat.

To learn more about how to properly install child safety seats, contact Child Passenger Safety Coordinator at your local county public health department, or call us at the Healthline at (800) 333-3212. ❖



Diabetes: Do you unknowingly suffer from this silent killer?

by Vella K. Black-Roberts, RD, MPH

According to the Centers for Disease Control and Prevention (CDC), as many as 798,000 new cases of diabetes are diagnosed annually. Do you or any child in your care have diabetes, or suspect it? You might.

Diabetes is a condition which makes it hard for the body to turn food into sugar. Sugar—or glucose, to use the medical term—is used by the body to produce energy. Diet and exercise are two of the most important factors in controlling diabetes, and both can affect blood glucose levels. Child care providers should always plan well-balanced meals and ample time for outside exercise for children and staff. This is important for everyone's good health and even more important for children or adults with diabetes. Sharing in advance the type of exercise and menus with families is important and will give them time to manage a child's insulin and meal needs for good control and maintenance.

Child care providers are not immune from this disease. Do you know if you have diabetes? If not, you should ask yourself these questions: "When was the last time I had my blood glucose level checked or had a complete blood work-up to check my cholesterol levels? Am I overweight by at least 10 percent? Do I have a regular exercise program? Do I have a family history of diabetes?" Experiencing any of the following symptoms may also be a telltale sign that you have diabetes:

- Extreme thirst
- Weight loss without any effort on your part
- Changes in your eating habits
- Frequent bathroom visits, especially at night
- Blurred vision
- Fatigue and infections that don't go away easily

Just as there are exceptions to every rule, health care professionals note that some people with diabetes don't exhibit any symptoms at all. So have regular checkups to be sure you are in good health.

For more information about diabetes, contact your local American Diabetes Association, health care provider, Child Care Food Program or the Child Care Healthline at (800) 333-3212. ❖

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Take action

(continued from page 1)

CCHP is currently working in three pilot counties (Alameda, Stanislaus and Ventura) to establish projects to provide these services, patterned after successful models in the Bay Area.

Take action in your community by helping Head Start and child care communities come together to share their mutual needs and assets. Talk with the Children's Services Coordinator in your county mental health program. Encourage them to talk to their colleagues in Alameda, Stanislaus and Ventura counties. Call the Healthline for technical assistance at (800) 333-3212. Garner support at your Local Child Care Planning Council and Prop. 10 meetings. Give testimony about your real-life experiences (conceal the identity of the child and family to maintain confidentiality) and *keep talking*. Soon others will join with you to build an effective mental health consultation program for your community. ❖

Study

(continued from page 4)

behavior problems at age 3. Finally, child outcomes could be predicted at 2 years of age by child-staff ratio, and child outcomes could be predicted by caregiver training and education at 3 years of age.

What this landmark study tells us is that we must advocate for improved standards in class size and staff ratios, we must support current efforts to maintain well-trained staff, and we must oppose any efforts to water down existing standards. These standards affect what we now know are the most critical years for brain development. Once the opportunity is lost, it can't be recovered again. ❖

Update on G-tube feeding in child care

Recently the Child Care Law Center contacted the California Department of Social Services regarding the state's allegedly illegal policy of forbidding licensed child care providers from providing gastronomy tube (g-tube) feedings. The state agreed not to cite the two programs identified by the Child Care Law Center.

For assistance on g-tube matters, contact Chris Palamountain at the Child Care Law Center at (415) 495-5498.

Legislative update

by Marsha Sherman, CCHP Director

The California legislature ended the 1999 session without passing **AB561** (Romero), the **Child Care Health Linkages** bill. The bill will be reviewed again in the next legislative session, but it will not begin from scratch. It has already been approved by the State Assembly and now must pass out of committee and be approved by the Senate and then signed by the Governor. We are working with the Governor's Office of Education to gain the Governor's support and to establish funding for the project in next year's state budget. Your letters to the Governor could help.

The **California CARES** bill (**AB212**), which would have supported child care providers who stay in the field and continue to take courses and attend conferences, was vetoed by the Governor. Discussions are going on now to decide the future of that legislation. Many local communities are attempting to place activities similar to both the Child Care Health Linkages and California CARES bills in their county Proposition 10 plan. ❖

Health and safety calendar

November

2. Rose Jenkins Conference on The Role of Mental Health in Infancy and Early Childhood, Sacramento. Call (916) 556-3480.

10-13. National Association for the Education of Young Children (NAEYC) 1999 Annual Conference, New Orleans. Visit their Web site at: www.naeyc.org/conferences/annual/1999/zocalo.htm

10-14. Multicultural Education: " Crossing Borders for Equity and Justice" 9th Annual Conference of the National Association for Multicultural Education (NAME), San Diego. Visit their Web site at: www.inform.umd.edu/NAME/conference.html

12-15. National Council on Family Relation's Annual Conference, Irvine. Call toll free (888) 781-9331 or visit their Web site at: www.winterse.a.ncfr.org.

December

3-5. 14th National Training Institute Conference for Infants & Toddlers, Anaheim. Call (703) 271-1296.

10-12. California Head Start Association State Conference: Coming Together for the New Millennium, Sacramento. Call (209) 772-3980.

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Resources

Products, books, furniture and posters described in this Resource section are brought to your attention so that you can see what is available. Child Care Health Connections does not endorse any of the items listed. We hope that you will evaluate these resources and decide their value for yourself.

Documents and materials

Early Childhood Caries Resource Guide was developed to assist health professionals and caregivers in the prevention of early childhood caries, also known as baby bottle tooth decay. Listing a variety of resources, this guide promotes the exchange of information to help children and their families learn healthy oral hygiene habits for a lifetime. To obtain a free copy of this publication, contact the resource center at **oralhealth@ncemch.org**/ or call (703) 356-1964.

Online Resources

Pact, An Adoption Alliance at **www.pactadopt.org** offers short articles for parents and child care providers pertaining to all biracial/biethnic children, not just those who are transracially adopted.

Readiness for Y2K. You may need to review and update your child care facility's disaster readiness plans for possible implementation in the event of a Year 2000 (Y2K) failure such as electrical power, water and sewage, communications, fire safety and security. The following Web sites will provide excellent basic information: **www.year2000.ca.gov, www.y2k.gov, www.year2000.com, www.dhs.ca.gov/y2k**.

National Maternal and Child Health Clearinghouse (NMCHC) offers various publications on oral health. Visit their Web site at **www.nmchc.org/**. A list of available titles may be viewed and printed using Adobe Acrobat Reader.

New Spanish Health & Safety Notes available from CCHP

1. El Asma en los Establecimientos de Cuidado Infantil (Asthma in the Child Care Setting)
2. Los Piojos: Un Problema Comun (Head Lice: A Common Problem)
3. Exclusion e Inclusion del Niño y Excusa for Enfermedad (Child Exclusion/Inclusion and Dismissal for Illness)
4. La Conexión Entre la Higiene y la Salud (The Health/Hygiene Connection)
5. Abuso Infantil (Child Abuse)

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